5. Research protocols indicate that the service or supply is experimental, investigational, or unproven. This applies for protocols used by the Covered Individual's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

For the purposes of the Medical and Dental Programs, the Plan Administrator or its authorized Claims Administrator makes the final decision as to whether services, supplies or devices are Experimental, Investigational or Unproven under this definition.

If a Covered Individual has a life-threatening Sickness or condition (one which is likely to cause death within one Year of the request for treatment), the Claims Administrator may, at its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, the Claims Administrator must determine that the procedure or treatment is promising, but Unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

EXPLANATION OF BENEFITS (EOB): A statement from a Claims Administrator or an insurance carrier that summarizes information by providing detailed content on account balances and claim activity.

FAMILY MEMBERS: Your family members who are eligible for coverage under the Plan as described in this SPD. Committed Partner and Committed Partner's Children are not Family Members for purposes of determining Qualified Life Events (however, notification requirements do apply for Qualified Life Events).

FSA: Flexible Spending Account.

FULLTIME EMPLOYEE: A person who is classified by Southwest as a "fulltime" Employee.

GENERIC: A Prescription Drug that is either (i) chemically equivalent to a Brand-name drug; or (ii) identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

GROSS DISABILITY BENEFIT: Is the lesser of percent of an Employee's monthly Covered Earnings (as determined by the plan in which they are enrolled) rounded to the nearest dollar or the Maximum Disability Benefit.

GROUP POLICY: The group Life Insurance policy issued by the Insurance Carrier to the policyholder and identified by the Group Policy number.

HEALTH CARE FSA: Health Care FSA is an account established to receive Your deposits to the Health Care FSA and from which Your eligible healthcare charges may be reimbursed.

HEALTH & WELLNESS TEAM: The Health & Wellness Team is a group of dedicated Southwest Employees in the People Department that administer the Plan at the direction of the Plan Administrator.

HEALTHCARE COVERAGE: Includes elected coverage under the Medical, Dental, Vision, and Health Care FSA Programs.

HOME HEALTH AIDE: The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY: An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare, *or*
- It is established and operated in accordance with the applicable licensing and other laws, *or*
- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home; *and*
  - It has a fulltime administrator; *and*
  - It maintains written records of services provided to the patient; *and*
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available; *and*
  - Its Employees are bonded and it maintains malpractice insurance; *and*
  - It does not primarily provide Custodial Services or care and treatment of the mentally ill.

HOSPICE: An agency that provides counseling and incidental medical services for a Terminally Ill Individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice, *or*
- It is licensed in accordance with any applicable state laws, *or*
- It meets the following criteria:
  - It provides 24 hour-a-day, 7 day-a-week service; *and*
  - It is under the direct supervision of a duly qualified Physician; *and*

- It has a nurse coordinator who is a registered graduate nurse with four Years of full-time clinical experience. Two of these Years must involve caring for Terminally Ill patients; *and*
- The main purpose of the agency is to provide Hospice services; *and*
- It has a fulltime administrator; *and*
- It maintains written records of services given to the patient; *and*
- It maintains malpractice insurance coverage.

A Hospice that is part of a Hospital will be considered a Hospice for the purposes of the Medical Program.

HOSPITAL: As it pertains to the **Medical Program** a Hospital is an institution, operated as required by law that is both of the following (i) primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians and (ii) has 24 hour nursing services. A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

As it pertains to **mental health benefits in the Medical Program**, the term Hospital also includes a chemical abuse/dependency treatment center, which is a facility that provides a program for the care of Chemical Abuse/Dependency according to a written plan approved and monitored by a Doctor. Such facility must be clinically supervised by a Doctor and meet one of the following criteria: (i) affiliated with a Hospital, other than the treatment facilities referenced below, under a contractual agreement with an established system for patient referral; (ii) accredited as such by the Joint Commission on Accreditation of Hospitals, or (iii) licensed, certified or approved as a Chemical Abuse/Dependency treatment program or center by other state agency having legal authority to so license, certify or approve. In addition, the term "Hospital" includes any facility approved by the Claim Administrator of the Medical Program for treatment which has been preauthorized.

As it pertains to the **Long Term Disability Plan**, a Hospital is an institution that mainly provides, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons; is supervised by a staff of Physicians; provides 24 hour a day registered nursing (RN) service; and is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home. An institution which does not provide complete surgical services, but which meets all the other tests listed above, will also be deemed a hospital if it provides services chiefly to patients all of whom have conditions related either by a medical specialty field or a specific disease category; and while confined, the patient is under regular therapeutic treatment by a Physician for the Injury or disease.

ILLNESS: See Sickness/Illness/Injury.

IN-NETWORK PROVIDER: A Physician, Hospital or other Provider who may lawfully provide covered services and who has contracted, directly or indirectly, with the Claims Administrator or Insurance Carrier to provide services to You and Your Covered Family Members. A Provider may enter an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network Provider for only some products. In this case the Provider will be an In-Network Provider for the health services and products included in the participation agreement, and an Out-of-Network Provider for other health services and products. The participation status of Providers will change from time to time.

INDEXED EARNINGS: For the first twelve months in which Monthly Benefits are payable, Indexed Earnings will be equal to Covered Earnings. After twelve Monthly Benefits are payable, Indexed Earnings will be an Employee's Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of (i) ten percent of the Employee's Indexed Earnings during the preceding year of Disability or (ii) the rate of increase in the Consumer Price Index (CPI-W) during the preceding Calendar Year.

INJURY: See Sickness/Illness/Injury.

INPATIENT REHABILITATION FACILITY: A long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

INSURANCE CARRIER: Any insurance carrier that funds and administers claims under the Plan. The name and contact information of insurance carriers is shown in Section 1 of this SPD.

IRS: The Internal Revenue Service of the United States of America.

LARGE CASE MANAGEMENT SERVICES: A professional medical management program for Covered Individuals who have suffered a Severe Personal Injury or Illness. Large Case Management Services include consulting with the Covered Individual and the attending Physician to develop a Plan of Alternative Medical Treatment and the coordination of all medical services required while under the program. Large Case Management Services are most often used when costs are likely to be extremely high and care needs very complex.

LEGEND DRUG: A Legend Drug is any medication that would require a prescription from the doctor and would be picked up at the pharmacy. This may be a controlled substance (narcotic) or a non-narcotic drug. The term is used to distinguish from over-the-counter drugs.

LIFE INSURANCE: Life insurance under the Group Policy.

MATERIAL DUTIES: Duties that are normally required for the performance of Your Own Occupation and that cannot be reasonably omitted or modified. However, to be at work in excess of 40 hours per week is not a material duty.

MAXIMUM DISABILITY BENEFIT: The maximum amount payable to an Employee.

MAXIMUM PLAN ALLOWANCE: The maximum amount reimbursed for each covered procedure determined annually through a review of proprietary filed fee data and actual submitted claims from Providers in the same geographical area with similar professional standing.

MEDICALLY NECESSARY OR MEDICAL NECESSITY: Services or supplies provided by a Hospital, Physician or other qualified Provider are Medically Necessary (as determined by the Claims Administrator, in its sole discretion) if they are:

- Required for the diagnosis and/or treatment of the particular condition, disease, injury or illness,
- Consistent with the symptom or diagnosis and treatment of the condition, disease, injury or illness,
- Not deemed to be Experimental, Investigational or Unproven as defined above,
- Commonly and usually noted throughout the medical field as proper to treat the diagnosed condition, disease, injury or illness, and
- The most fitting supply or level of service which can safely be given to the Covered Individual. When assessing the Medical Necessity of inpatient care, medical symptoms or conditions must require that the proposed services or supplies cannot safely be delivered on an outpatient basis.

The diagnosis, treatment, service and supply with respect to a condition, disease, injury or illness is not Medically Necessary if made, prescribed or delivered solely for convenience of the patient or Provider. The fact that a Physician, Dentist or other Provider has performed or prescribed a procedure or treatment does not mean that it is Medically Necessary.

For purposes of the mental, emotional, behavioral, and chemical abuse/dependency benefits only, the terms "Medically Necessary," "Appropriate," and "Medical Necessity" mean a service or supply that the Claims Administrator determines:

- Is an adequate and essential therapeutic response provided for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific Covered Individual's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent in ICD-9CM), *and*
- Is reasonably expected to improve the Covered Individual's illness, condition, or level of functioning, *and*
- Is safe and effective according to nationally accepted standards of clinical evidence generally recognized by mental health or chemical abuse care professionals or publications, *and*
- Is the appropriate and Cost Effective level of care that can safely be provided for the specific Covered Individual's diagnosed condition in accordance with the professional and technical standards adopted by the Plan Administrator or its authorized Claims Administrator.

The Plan Administrator or its authorized Claims Administrator, in its sole discretion, reserves the right to make the final decision as to whether services or supplies are Medically Necessary under this definition.

The first 31 days of inpatient treatment mandated by the FAA for the treatment of Alcohol Abuse/Dependency or Chemical Abuse/Dependency will be deemed Medically Necessary for Pilots and Flight Attendants.

For purposes of the Vision Program only, services and materials that are medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative. Contact lenses are medically necessary if You or Your Covered Family Member has: (i) keratoconus or irregular astigmatism, (ii) anisometropia of 3.50 diopters or more, (iii) post cataract surgery without intraocular lens, or (iv) visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

MEDICAID: The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

MEDICARE: The program of medical care benefits provided under Title XVIII of the Federal Social Security Act (Federal Health Insurance for the Aged) as it is now or as it may be amended.

MEMBER SERVICES: The customer service department of the Claims Administrator.

MENTAL DISORDER: Any mental, emotional, behavioral, psychological, personality, cognitive mood or stress-related abnormality, disorder, disturbance dysfunction or syndrome, regardless of cause, including any biological or biochemical disorder or imbalance of the brain. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, or anxiety and anxiety disorders.

MENTAL DISORDER TREATMENT/SUBSTANCE USE DISORDER/DEPENDENCY TREATMENT: Substance Use Disorder/Dependency Treatment is treatment for any Mental Illness involving Substance Use Disorder/Dependency. Mental Disorder Treatment is treatment for any other Mental Illness. All inpatient services, including Room and Board, given by a Treatment Center, mental health facility or area of a Hospital which provides Mental Disorder Treatment or Substance Use Disorder/Dependency Treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment/Substance Use

Disorder/Dependency Treatment, except in the case of multiple diagnoses. If there are multiple diagnoses, only the treatment for the Mental Illness is considered Mental Disorder Treatment/Substance Use Disorder/Dependency Treatment. Detoxification services given prior to and independent of a course of psychotherapy or Substance Use Disorder/Dependency Treatment are not considered Mental Disorder Treatment or Substance Use Disorder/Dependency Treatment.

Month: A period starting at 12:01 a.m. on any day in a given calendar Month, and ending at 12:01 a.m. on the same numbered day in the next calendar Month. If the next calendar Month does not have a same numbered day, the Month will end at 11:59 p.m. of the last day of that calendar Month. (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; 12:01 a.m. of May 31 through 11:59 p.m. of June 30.)

Monthly Benefit Payable: The Gross Disability Benefit less Other Income Benefits as defined in the LTD Program section of this SPD.

Network Pharmacy: A retail or mail order pharmacy that has (i) entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons; (ii) agreed to accept specified reimbursement rates for Prescription Drugs; and (iii) been designated by the Claims Administrator as a Network Pharmacy.

Non-Continuous Pay Period: Non-Continuous Pay Period as described in the Leave of Absence section of this SPD.

Other Coverage: Coverage under any other plan under which the individual was provided health care whether employer provided, self-purchased or provided by the government; provided that for purposes of any provisions relating to Committed Partners, Other Coverage does not include Medicare.

Other Income Benefits: With respect to the Long Term Disability Program, other Income Benefits means amounts received including, but not limited to, (i) any sick pay or other salary continuation except vacation pay, which when added to the Monthly benefit payable, without any reduction for Other Income Benefits, is more than 100% of Your adjusted predisability earnings; (ii) any amount You receive, or are eligible to receive under workers' compensation or other similar acts, state disability or any other group coverage, including amounts for partial or total disability, whether permanent, temporary or vocational; (iii) any amounts from social security (either Employee or family) or other similar laws; (iv) other earnings or compensation; and (vi) any disability or retirement benefits paid or allocated to You under a retirement plan except any amount attributable to Your contributions under such Plan or any amount that You would have received upon termination of employment without being terminated or disabled.

Out-of-Network Provider: A Physician, Hospital or other Provider who may lawfully provide covered services but who has not contracted, directly or indirectly, with the Claims Administrator or Insurance Carrier to provide services to You and Your Covered Family Members.

Out-of-Pocket Maximum: The maximum amount you pay out-of-pocket every Calendar Year. For additional information, refer to the Medical Program section of this SPD.

Own Occupation: The occupation that You are routinely performing when Your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed for Your specific employer or at Your location or work site; and without regard to Your specific reporting relationship.

Palliative: An alleviating measure. To relieve but not cure.

Participant: An Employee or Family Member or a retired Employee whose coverage has become effective under the Plan.

Partner Policy: The Southwest Airlines Co. Committed/Registered Partner Program Policy. The Partner Policy is available at SWALife>About Me>My Benefits>Information and Forms.

Parttime Employee: A person who is classified by Southwest as a "parttime" Employee.

PDL Management Committee: See Prescription Drug List (PDL) Management Committee.

Personal Health Support: A program provided by the UnitedHealthcare Claims Administrator and designed to encourage an efficient system of care by identifying and addressing possible unmet health care needs.

Physical Disease: A physical disease entity or process that produces structural or functional changes in Your body as diagnosed by a Physician.

PHYSICIAN: Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law. Physician does not include You or Your Spouse or Committed Partner, or the brother, sister, parent or child of either You or Your Spouse or Committed Partner.
- For purposes of the **Life Insurance Program**, a licensed M.D. or D.O, acting within the scope of his or her license. Physician does not include You or Your Spouse or Committed Partner, or the brother, sister, parent or child of either You or Your Spouse or Committed Partner.
- For purposes of the **LTD Insurance Program**, a person who is a legally qualified Physician, and to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a Physician. Regular care of a Physician means You are attended by a Physician: who is not You or related to You; who is practicing within the scope of his or her license; who has the medical training and clinical expertise suitable to treat Your disabling condition; who specializes in psychiatry, if Your disability is caused, to any extent, by a mental health or psychiatric condition; and whose treatment is: consistent with the diagnosis of the disabling condition, according to guidelines established by medical, research and rehabilitative organizations, and administered as often as needed.

PLAN: The Southwest Airlines Co. Welfare Benefit Plan that provides medical, dental, and wellness and other benefits on a self-funded basis and vision, disability, and life-insurance on an insured basis.

PLAN ADMINISTRATOR: The Southwest Airlines Co. Board of Trustees is the Plan Administrator.

PLAN YEAR: The 12-Month period from each January 1 through December 31.

PREDOMINANT REIMBURSEMENT RATE: The amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

PREEXISTING CONDITION: For purposes of the Regular Plan medical option, Preexisting Condition shall have the meaning set forth in the Medical Program section of this SPD. For purposes of the LTD Program only, Preexisting Condition shall have the meaning set forth in the LTD Insurance Program section of this SPD.

PREGNANCY: Your pregnancy, childbirth or related medical conditions including complications of pregnancy.

PRESCRIPTION BENEFIT MANAGER: The Claim Administrator for the prescription drugs.

PRESCRIPTION DRUG: A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include the following drugs for the treatment of diabetes: insulin and certain diabetic supplies including insulin syringes with needles, blood testing strips—glucose; urine testing strips – glucose, ketone testing strips and tablets, lancets and lancet devices, insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets, and glucose monitors.

PRESCRIPTION DRUG CHARGE: The rate the Claims Administrator has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

PRESCRIPTION DRUG LIST (PDL): A list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per Calendar Year).

PRESCRIPTION DRUG LIST (PDL) MANAGEMENT COMMITTEE: The committee that the Claims Administrator designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

PREVENTIVE CARE MEDICATIONS: The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:
- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force;*
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration; or*
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

PRIMARY CARE PHYSICIAN: The term Primary Care Physician means a Physician: (a) who qualifies as a Provider in general practice, internal medicine, family practice, or pediatrics; and (b) who has been selected by a Covered Individual, as authorized by Member Services, or by the Claims Administrator to provide or arrange for medical care for You or any of Your Covered Family Members.

PROGRAM: Any benefit program offered under the Plan.

PROVIDER: is an individual or an institution that provides preventive, curative, promotional, or rehabilitative health care services in a systematic way to individuals, families, or communities.

QUALIFIED LIFE EVENT: The events specified in this SPD that qualify as either a Change in Status or Special Enrollment and permit the addition (or deletion) of coverage outside of annual enrollment in for an Family Member upon written notification within 30 days of the event, subject to Statement of Health rules.

REASONABLE AND CUSTOMARY CHARGE(S): Charges which the Plan Administrator or its authorized Claims Administrator determines do not exceed the amount usually charged by most Providers in the same geographic area for services, treatment or supplies as described above. A special provision will apply when there are no Providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, the Plan Administrator or its authorized Claims Administrator will decide whether the charge is appropriate based on: (i) the complexity involved; (ii) the degree of professional skill required; (iii) the cost of the services or supplies; and (iv) other pertinent factors. Payment of flat rate charges may be declined when procedures, fees and/or time involved are not itemized.

REHABILITATION FACILITY: A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

RESIDENTIAL TREATMENT CENTER: A facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements: (i) it is established and operated in accordance with applicable state law for residential treatment programs; (ii) it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee; (iii) it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and (iv) it provides basic services in a 24-hour per day, structured milieu, including at a minimum room and board, evaluation and diagnosis, counseling, and referral and orientation to specialized community resources. A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

RETIREMENT PLAN: A defined benefit plan or defined contribution plan providing disability or retirement benefits for Employees but does not include a profit sharing plan, a thrift or savings plan, a deferred compensation plan, a 401(k) plan or a plan under IRC Section 408(k) or 457, an Individual Retirement Account (IRA), a Tax Sheltered Annuity (TSA) under IRC Section 403(b), a stock ownership plan, or a Keogh (HR-10) plan.

ROOM AND BOARD: Charges by a Hospital or Skilled Nursing Facility for the room, meals, and routine nursing services for Covered Individuals confined as bed patients. Such term does not include the professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

SCLEROTHERAPY: an injection of a chemical to treat varicose veins

SEAT BELT SYSTEM: A properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat Belt System will include a lap belt alone, but only if the automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt System does not include a shoulder restraint alone.

SEMI-PRIVATE ROOM: A Semi-private Room is (i) a room with two or more beds or (ii) a private room but only if necessary in terms of generally accepted medical practice or when a room with two or more beds is not available.

SERVICES (VISION PROGRAM ONLY): An examination, material selection, fitting of glasses and related adjustments.

SEVERE PERSONAL INJURY OR ILLNESS: This term includes, but is not limited to amputations; multiple fractures; spinal cord injury; cerebral vascular accident; major head trauma; acquired immune deficiency syndrome (AIDS); multiple sclerosis; high risk infants; high risk pregnancy; severe burns; amyotrophic lateral sclerosis (ALS); and end stage cancer

SICKNESS/ILLNESS/INJURY: The term Injury will mean a non-work related accidental bodily injury. The term Sickness or Illness means a physical or mental illness. The donation of an organ or of tissue by a Covered Person for transplanting into another person is considered to be an illness of the person receiving the donation.

SIGNIFICANT BREAK IN COVERAGE: a period of 63 consecutive days during which a person does not have any Creditable Coverage. Waiting periods are not counted when determining whether a person has incurred a Significant Break in Coverage. A waiting period is any period of time that must pass before a person is eligible for Healthcare Coverage (for individual coverage, a waiting period is any period after the filing of a complete application for coverage and before the first day of coverage or, if no coverage results, before the day coverage is denied or rejected or the application lapses). In addition, for a person who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the person lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a Significant Break in Coverage has occurred.

SKILLED NURSING FACILITY: A Hospital or nursing facility that is licensed and operated as required by law.

SOUTHWEST: Southwest Airlines Co.

SPD: Refers to this Southwest Airlines Co. Welfare Benefit Plan Summary Plan Description.

SPOUSE: A person who qualifies as a spouse for purposes of the Internal Revenue Code of 1986 as in effect on January 1, 2004.

STATEMENT OF HEALTH: For purposes of the Life Insurance Program, when required, an applicant must provide evidence of insurability which includes the following steps (i) complete and sign the medical history statement provided by the Life Insurance Carrier; (ii) sign the form authorizing the Life Insurance Carrier to obtain information about the applicant's health; (iii) undergo a physical examination, if required by the Life Insurance Carrier, which may include blood testing; and (iv) provide any additional information about the applicant's insurability that the Life Insurance Carrier may reasonably require.

STEPCHILD: A child of a Spouse by a previous union.

SUMMARY PLAN DESCRIPTION (SPD): Refers to this Southwest Airlines Co. Welfare Benefit Plan Summary Plan Description.

SWAPA: Southwest Airlines Pilots' Association.

THERAPEUTIC CLASS: A group or category of Prescription Drug with similar uses and/or actions.

THERAPEUTICALLY EQUIVALENT: When Prescription Drugs have essentially the same efficacy and adverse effect profile.

TREATMENT CENTER: A facility which provides a program of effective Mental Disorder Treatment/Substance Use Disorder/Dependency Treatment and meets all of the following requirements: (i) it is established and operated in accordance with any applicable state law; (ii) it provides a program of treatment approved by a Physician and the Claims Administrator;(iii) It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and it provides basic services including at a minimum room and board (if the Plan provides inpatient benefits at a Treatment Center), evaluation and diagnosis; counseling; and referral and orientation to specialized community resources. A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

URGENT CARE: Care for the sudden onset of a Sickness or Injury that is non-life threatening, but requires medical attention sooner than the next working day.

USUAL AND CUSTOMARY CHARGE: The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

YOU/YOUR: As applicable in this SPD, You/Your means either (i) an Employee or former Employee of Southwest Airlines Co. who is eligible for coverage under the Plan, who is properly enrolled in the Plan, and who is classified by the Plan Administrator as the primary Covered Individual (and not as a Family Member), or (ii) any Family Member.

END OF SECTION

GENERAL INFORMATION

ELIGIBILITY

ELIGIBILITY GENERAL REQUIREMENTS: You are eligible to participate in the Plan if You: (i) are classified by Southwest as an active Fulltime or Parttime Employee; **and** (ii) have completed Active Work for the required eligibility period; **and** (iii) are not in an ineligible classification of Employees. **Southwest and its third party administrators may audit dependent eligibility at any time. It is each Employee's responsibility to provide any and all information requested. Falsifying eligibility documentation, claims, or otherwise attempting to obtain benefits or coverage inappropriately could result in denial of claims, termination of benefits, and other disciplinary measures, up to and including termination of employment.**

AIRTRAN ELIGIBILITY: The 30-day Eligibility Period is waived for any Employee that was an Employee of AirTran Airways, Inc. on the day immediately preceding the Employee's Southwest Airlines date of hire.

REQUIRED ELIGIBILITY PERIOD: Your required eligibility period is a period of days or Months from Your date of hire as set forth in the Eligibility Chart and is determined based on (i) whether You are a Fulltime or Parttime Employee, and (ii) whether You choose the BenefitsPlus or the Regular Plan option.

- You must complete **Active Work** for the required eligibility period. You are not Actively at Work on any day for which You are on a leave of absence.
- To receive a benefit in the **LTD Program,** You must meet additional work requirements for your work group as follows. **Flight Attendants** must have flown an average of at least 30 trips per Month in the preceding six consecutive calendar Months, or during the period of employment if less than six Months from the date of disability as determined by the Insurance Carrier. **Pilots are** not eligible for coverage in the Plan's LTD Program. (Pilots may be eligible for a long-term disability program sponsored by SWAPA.) **All other Employees** must be regularly working at least 20 hours each week in the preceding six consecutive calendar Months, or during the period of employment if less than six Months from the date of disability as determined by the Insurance Carrier.

INELIGIBLE CLASSIFICATIONS OF EMPLOYEES: You are **not** eligible to participate in the Plan if You are (i) a nonresident alien who receives no U.S. source income from Southwest, (ii) a resident of Puerto Rico, or (iii) You are classified by Southwest in the following ineligible classifications: temporary, short-term, interim, seasonal, or leased Employee; contractor or independent contractor; Employee who has coverage under another group health plan sponsored by Southwest; intern; or extern.

ELIGIBLE FAMILY MEMBERS: You may enroll Your Family Members in the Medical, Dental, and Vision Programs, and Life Insurance Program as described in this SPD if You provide the required documentation and any additional information required by the Plan Administrator to prove eligibility within the specified enrollment period.

INELIGIBLE FAMILY MEMBERS: You may **not** enroll the following ineligible family members.

- A child who is eligible to be covered under the Plan (or any other group health plan sponsored by Southwest) as an Employee or former Employee, or who has benefits due under any extension of such coverage.
- A child whose parents (divorced or otherwise) are both covered under the Plan (or any other group health plan sponsored by Southwest) as Employees or former Employees may be covered Family Members of either the mother or father, but not both.
- A spouse who is eligible to be covered under the Plan (or any other group health plan sponsored by Southwest) as an Employee or former Employee or who has benefits due under any extension of such coverage, may not be covered as both an Employee (or former Employee) and as a Family Member.
- A partner who is eligible to be covered under the Plan (or any other group health plan sponsored by Southwest) as an Employee or former Employee or who has benefits due under any extension of such coverage, may not be covered as a Committed Partner of an Employee.
- In most cases, if You drop coverage for a Committed Partner or the Child of a Committed Partner, then You may not reenroll that partner or child or enroll a new partner for a period of 12 Months.

GENDER CHANGE: If you would like to change your gender for purposes of the Plan, then you must contact the Health & Wellness Team, complete a Gender Designation Change Form , and provide all requested documentation.

DISABLED CHILDREN: You must contact the Health & Wellness Team and the Claims Administrator no later than 30 days after your child reaches age 26 to request continued coverage for children who satisfy the following Plan requirements: (i) mentally or physically disabled and unable to earn his or her own living if proof of the child's incapacity is furnished to the claims administrator within 30 days after the date his or her coverage would have ended due to reaching age 26; and (ii) actually dependent on you for the majority of his or her support and covered on the date just prior to the day his or her coverage would have ended due to reaching age 26.

Eligibility Period Chart for Fulltime and Parttime Employees

	Eligibility Period: Fulltime Employees		Eligibility Period: Parttime Employees[2]	
	BenefitsPlus	Regular Plan[1]	BenefitsPlus	Regular Plan[1,3]
Medical	30 Days[4]	30 Days[4]	30 Days	6 Months
Basic Dental	30 Days[4]	6 Months	30 Days	6 Months
Optional Dental	30 Days[4]	Not Available	30 Days	Not Available
Vision	30 Days[4]	60 Days[5]	30 Days	60 Days[7]
Health Care Spending Account	30 Days[4]	Not Available	30 Days	Not Available
Dependent Care Spending Account	30 Days[4]	Not Available	30 Days	Not Available
Basic Life Insurance	30 Days[4]	30 Days	30 Days	30 Days
Optional Life Insurance	30 Days[4]	30 Days	30 Days	30 Days
AD&D	30 Days[4]	30 Days	30 Days	30 Days
Spouse, Committed Partner, Child Life Insurance	30 Days[4]	Not Available	30 Days	Not Available
Basic LTD	30 Days[6]	Not Available	30 Days	Not Available
Optional LTD	30 Days[6]	90 Days[6]	30 Days	90 Days

(1) Coverage is not available to Committed Partners or children of Committed Partners.
(2) Coverage is not available to Pilots or Flight Attendants.
(3) Coverage is not available to Parttime Employees in the following classifications: Customer Service Agents; Flight Crew Training Instructors; Freight Agents; Noncontract Employees; Operations Agents; Provisioning Agents; Ramp Agents; and Customer Representatives.
(4) Coverage is available to Pilots on date of hire, however, many of the options require that the Pilot actively enroll in the benefit option.
(5) Coverage is available only to Employees in the following classifications: Aircraft Appearance Technicians; Customer Service Agents; Dispatchers; Flight Simulator Technicians; Mechanics; Pilots; Customer Representatives; and Stock Clerks.
(6) Coverage is not available to Pilots.
(7) Coverage is available only to Employees in the following classifications: Aircraft Appearance Technicians; Dispatchers; Flight Simulator Technicians; Mechanics; Pilots; and Stock Clerks.

Eligibility Documentation

• To enroll in the Plan, within 30 days of Your date of hire, You must complete a Family Member Documentation Form available on SWALife>About Me>My Benefits, attach the eligibility documentation as required in the Eligibility Documentation Chart, and return the form and all required documents to the Health & Wellness Team. If documentation cannot be provided within the 30 day eligibility period as required by the Plan Administrator, You must contact the Health & Wellness Team within the 30 day eligibility period and submit in writing a request for an extension. If the request is approved, the period for submitting proof of eligibility will be extended an additional 15 days. If You do not return the required form and documentation within 30 days or within 45 days if Your request for an extension was approved, then You may not enroll Your Family Members until the next annual enrollment period, unless You have a Qualified Life Event. See the "MidYear Changes to Enrollment and Elections" in this chapter for additional information.

• The Plan or Claims Administrators may require the use of Social Security and/or other identifying numbers or information to enroll You and Your Family Members and/or Committed Partner.

• To continue coverage, You may be required to provide additional documentation or update information previously provided and You must provide such documentation when requested and prior to any deadline for submission.

ELIGIBILITY DOCUMENTATION CHART

Family Member	Description	Required Documentation
Spouse	Your lawful Spouse (if not legally separated from You, the Employee) who qualifies as a Spouse for purposes of the Internal Revenue Code of 1986(as in effect on January 1, 2004.	1. Copy of Marriage Certificate issued by a governmental agency (certified translated copy if in a foreign language); 2. Social Security Number 3. And ONE document from ONE of the options below: **Option 1** Page 1 of your current Years filed Federal tax return that lists your Spouse and filing status. **Option 2** Page 1 of your previous Year's filed Federal tax return showing your filing status and listing your Spouse AND a copy of your current Year IRS Form 4868 requesting a filing extension. **Option 3** One item from the list below. • Joint Ownership Document—examples include: mortgage statement, credit card statement, car note, bank statement, school taxes, or utility bills dated any time in the last three Months listing you and your Spouse • Rental/lease agreement, deed, or property tax statement/appraisals dated anytime in the last 12 Months listing you and your Spouse • Homeowner's insurance policy currently in effect listing you and your Spouse • Auto insurance policy currently in effect listing you and your Spouse • Automobile registration currently in effect listing you and your Spouse ***If you were married within the last 12 Months, then you only need to submit a copy of your Marriage Certificate.* (Marriage License alone is not adequate.)
Natural Child	Your natural child up to age 26.	1. Copy of Birth Certificate issued by a governmental agency, Hospital Birth Record (for newborns), or other legal document establishing parentage. (Employee must be listed on the birth certificate, hospital birth record or other legal document.) 2. Social Security Number
Stepchild	Your stepchild up to age 26 who is a child of your current Spouse by a previous union.	1. Copy of Birth Certificate issued by a governmental agency or other legal document establishing parentage. (Employee's Spouse must be listed on birth certificate or other legal document) 2. Social Security Number
Legally Adopted Child (or Child Placed for Adoption) [1]	Your legally-adopted child, including child placed for adoption up to age 26.	1. Copy of Adoption (or Adoption Placement) Orders proving legal obligation and issued by a Court or other legal authority. 2. Social Security Number
Child for Whom you Have a Legal Obligation	Child for whom you (or, alternatively, you and your Spouse) have been appointed by a court of competent jurisdiction as the person(s) having custody of the child and the sole legal right and obligation to provide support and medical care for the child, but only if the child resides in your household on a permanent basis, and the child's parents are deceased, or the parental rights of the child's parents are permanently terminated, or the Plan Administrator determines, in its sole discretion, that the child's parents are totally disabled and financially unable to provide any support or care for the child.	1. Copy of Birth Certificate issued by a governmental agency; 2. Court Documentation proving your custody and the sole legal right and obligation to provide support and medical care for the child; proof the child lives in your household on a permanent basis; proof the child's parents are deceased or have had their parental rights permanently terminated (or proof the child's parents are totally disabled and financially unable to provide any support or care for the child). 3. Social Security Number
Disabled Child	Your disabled children up to the age of 26 are covered under the eligibility guidelines described above. Your disabled children over age 26 may be eligible for continued coverage.	For disabled children over age 25, a Physician's statement showing proof of incapacity is required. Contact Health & Wellness Team for the appropriate forms.
Committed Partner	Your Committed Partner must satisfy all of the requirements as stated in the Partner Policy. Your eligible Committed Partner may only be enrolled in BenefitsPlus, as well as the Dental Plan and the Vision Plan. You may enroll in the Committed Partner Program for Medical Coverage and/or Passes at any time during the Calendar Year. You may find the Partner Policy and an enrollment packet on **SWALife** >About Me >Launch About Me Self-Service >My Benefits >Information and Forms.	See the Partner Policy for required proof of eligibility (available at **SWALife** or upon request from the Health & Wellness Team).
Registered Partner (travel privileges only)	Registered Partners are not eligible for benefits under the Plan, but may be eligible for Southwest Airlines Co. travel privileges.	For travel privileges only, see the Partner Policy for required proof of eligibility (available at **SWALife** or upon request from theHealth & Wellness Team).

[1] **For former AirTran Employees only:** If you are the guardian of a child who is Your dependent for federal tax purposes and this child was enrolled by You and covered under an AirTran health plan on the date immediately preceding the date You became a Southwest Employee, then for purposes of initial eligibility for the Plan for this child, You will only be required to provide the following documentation: either (i) a notarized document that states that You are the legal guardian of the child and a copy of Your current tax return which lists the child as a tax dependent or (ii) a letter from the child's school establishing residency of the child with You. This eligibility will expire on April 30, 2014. Prior to that date You must provide all standard Southwest required documentation to continue coverage for the child. If you do not provide the documentation prior to April 30, 2014, coverage for the child will terminate on April 30, 2014.

ENROLLMENT

GENERAL ENROLLMENT REQUIREMENTS:

- You must enroll via www.swalife.com and your enrollment constitutes your agreement to make all required contributions.

- If You are a new Employee, You must enroll within **30 days** of Your Southwest hire date. **If You do not elect or decline** medical and dental coverage within 30 days of Your date of hire, then You acknowledge that You will be automatically enrolled for coverage under the BenefitsPlus Choice Plus Plan medical option and Basic dental at the Employee Only level, and that You will not be able to change that coverage until the following annual enrollment, and You agree to such automatic enrollment and authorize Southwest Airlines to deduct from my pay the contributions required of all Southwest Employees receiving that level of coverage.

- In Years following the Year that You are hired, You may enroll during the annual enrollment period. Under certain circumstances, You may be eligible to enroll outside the annual enrollment period if You have a Qualified Life Event as described in the "MidYear Changes to Enrollment and Elections" section of this chapter.

- If You are an inactive Employee during an enrollment period, then Your enrollment will be subject to special rules as described in the Leave of Absence section of this SPD.

REHIRED EMPLOYEES:

- If You terminate employment while eligible for coverage and are rehired within 30 days in the same classification or in another classification that is eligible for the same benefits, You will be enrolled in the same Programs and coverage levels that You had on the day before Your employment ended. If the date Your employment ended or the date You were rehired occurred during the annual enrollment period, the Plan Administrator will determine if You made new and valid elections during the annual enrollment period. If so, You will be enrolled in Your elected plans on the date You are eligible or January 1, whichever is later.

- Although You may be enrolled in the same plans, there is a lapse in coverage between Your termination date and Your rehire date. Benefits are effective on Your rehire date.

- If You are rehired more than 30 days from the date Your employment ended with Southwest or You are rehired in a different classification that is not eligible for the same benefits, Your eligibility to participate is determined under the same rules as apply to a newly hired Employee.

REINSTATED EMPLOYEES: If You are reinstated, You will be eligible to participate in the Plan based on the terms of Your reinstatement. If the date Your employment ended or the date You were reinstated occurred during or after annual enrollment, the Plan Administrator will determine if You are eligible to make annual enrollment elections based on the terms of Your reinstatement and if You made new and valid elections during annual enrollment.

ELECTING COVERAGE

NEW HIRES: Upon first becoming eligible to participate in the Plan, You will receive information and instructions on how to enroll in benefits and select coverage under the Plan by the deadline date.

NEW HIRES DEFAULT COVERAGE: As a new hire, if You do not properly enroll by the deadline date, You will receive the following default coverage in the BenefitsPlus program.

Program	New Hire Automatic Enrollment in Default Coverage in BenefitsPlus
Medical	Choice Plus for Employee Only
Dental	Basic for Employee Only
Vision	No Coverage
Spending Accounts	No Participation
Basic LTD	Employee Coverage (except Pilots)
Optional LTD	No Coverage
Basic Life	Employee Coverage
Optional Life	No Coverage
AD&D	No Coverage
Spouse/Committed Partner/Child Life	No Coverage

▪ If You are married to a Southwest Employee, then the default coverage information above does not apply. Your coverage will be as follows:

Program	New Hire Married to Another Southwest Employee
Medical, Dental, & Vision	You will automatically be enrolled in the same Programs that Your Spouse is enrolled in for the remainder of the Year. Your Spouse will be the primary Employee for coverage for Your family and You will continue to file claims under his or her Social Security Number or Alternate ID.
Health Care FSA	You must enroll if You would like to participate.
Dependent Care FSA	You may not participate.
Basic LTD, Optional LTD, Basic Life, Optional Life, AD&D	You must enroll if You would like to participate.
Spouse Life Insurance	You may not elect coverage.

CHOOSING YOUR BENEFITS: Southwest offers two categories of benefits, BenefitsPlus and the Regular Plan, and You must choose all of Your benefits in either the BenefitsPlus or the Regular Plan category.

▪ Committed Partners (and their children) and Parttime Employees who are Customer Service Agents, Flight Crew Training Instructors, Freight Agents, Noncontract Employees, Operations Agents, Provisioning Agents, Ramp Agents, and Customer Representatives are **not** eligible to enroll in the Regular Plan.

▪ If You choose to enroll a Committed Partner, then You must enroll in BenefitsPlus and You must complete and/or provide all information required by the Partner Policy.

▪ The Medical, Dental, and Vision Programs are unbundled so that at enrollment You may pick the coverage tier level that works best for Your family. (Example: You may elect Employee, Spouse, and Child for the Medical Program and elect Employee and Spouse only for the Dental Program). Individual elections may also be made for the Life, AD&D, and LTD Programs. Employees who are married to each other may not elect Spouse Life.

▪ If You elect a level of coverage which includes Your Family Members, then You will only receive the level of coverage You elect for the individuals for whom You have met all eligibility documentation requirements.

ANNUAL ENROLLMENT: Each Year during annual enrollment, You will receive information and instructions on how to change or cancel coverage You currently have or, if You are eligible but have not yet enrolled, how to enroll in benefits and select coverage under the Plan. **The information will also state the deadline by which You must enroll and elect coverage. If You enroll prior to the deadline, then the coverage You choose will be effective for the next Plan Year. If You miss the deadline, then Your elections will be invalid and You will remain enrolled in Your prior coverage except any prior FSA Program elections will be terminated and You will not be allowed to participate in the FSA Program for the Plan Year. If You were not previously enrolled for coverage, You will not be enrolled.**

ANNUAL ENROLLMENT LIMITATIONS FOR SOUTHWEST EMPLOYEES MARRIED TO SOUTHWEST EMPLOYEES:

▪ BENEFITSPLUS: If You and Your Spouse are both Southwest Employees and enroll or are enrolled in BenefitsPlus, then Your benefits under certain Programs are merged and one Employee must be designated to be the primary Employee and the other the dependent Employee.

▪ The **primary Employee** must enroll as a family unit for coverage and may change Medical, Dental, and Vision Program elections and will be responsible for all health premiums. The primary Employee may elect to participate in the Dependent Care FSA. Only the primary Employee may elect Spouse Life Insurance.

▪ Both the primary Employee and the dependent Employee may make changes to their individual Health Care FSA, Life Insurance, Child Life Insurance, AD&D, and LTD Program coverage.

▪ REGULAR PLAN: If You and Your Spouse are both Southwest Employees and enroll or are enrolled in the Regular Plan then each of You must make changes to Your own coverage.

No Coverage:

- Under BenefitsPlus, You may decline all Medical and/or Dental coverage for You and Your Family Members and You will receive extra pay. If You elect "No Medical Coverage" and/or "No Dental Coverage," then You and Your Family Members are not eligible to receive any Benefits under that Program.

- If you elect No Coverage, it is important to note that You and Your Family Members who are over age 19 may be subject to the pre-existing condition limitations if You later enroll in the Regular Plan unless You provide proof of Creditable Coverage in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

- If You elect No Coverage and the Health & Wellness Team receives a qualified medical support order, then, unless You complete a Life Event Change Form to address the required changes, You and the court ordered dependents will automatically be enrolled into the Choice Plus Plan medical option in the Medical Program, Basic Dental in the Dental Program, and the Vision Program to the extent the order requires such coverage.

- If You are married to a Southwest Employee, neither the primary Employee nor the dependent Employee are eligible for No Coverage compensation for the Medical Program or Dental Program unless both the primary Employee and the dependent Employee elect No Coverage.

Timing of Contributions, Premiums, and Extra Pay

General Information: The date that You begin to pay contributions/premiums for Your coverage or the date You begin to receive extra pay for certain coverage is dependent on when Your coverage begins. The date that You cease to pay contributions/premiums for Your coverage or the date You cease to receive extra pay for certain coverage is dependent on when Your last paycheck is issued.

- **If coverage begins on the 1 through the 15th of the Month,** You must pay the full Monthly contributions/premiums for that Month, or, if applicable, You will be eligible to receive Your full Monthly extra pay for that Month.

- **If coverage begins on the 16th through the end of the Month,** You do not have to pay the Monthly contributions/premiums for that Month. You must pay the full Monthly contributions/premiums and, if applicable, extra pay will begin in the next Month.

- **The date that You cease to pay contributions/premiums for Your coverage or the date You cease to receive extra pay for certain coverage depends on when Your last paycheck is issued. If coverage ends on the 1st through the 15th of the Month, then You must pay premiums through Your last paycheck issued. If coverage ends on the 16th through the end of the Month, then You must pay premiums through Your last paycheck issued.**

- **If Your paycheck(s) will not cover the full amount of contributions/premiums that You owe, You must make arrangements with the Health & Wellness Team to pay for Your elected coverage with a personal check or money order within the Month that You cannot pay the contributions/premiums via payroll deduction.**

- Except as provided otherwise in this SPD, if You do not pay for Your contributions/premiums as elected, the unpaid contributions/premiums may be deducted from any benefits payable under the Plan and/or Your coverage may be canceled retroactive to the end of the period for which contributions/premiums were last paid.

- If Your coverage is canceled, You may be required to repay the Plan for any benefit claim payments that were made following the end of the period for which contributions/premiums were last paid or collected.

- In the case of a Qualified Life Event, if You **do not** submit required Family Member eligibility documentation within 30 days from the date of the event (unless a longer election period is provided by law), the Family Member will not be added to coverage, and any additional contributions/premiums for that Family Member's coverage will be refunded.

TAX INFORMATION: Contributions/premiums will be deducted from each paycheck on a before-tax or after-tax basis, depending on the coverage elected, including any retroactive amounts due.

- **Before-tax premiums/contributions** are deducted from Your pay before federal income, FICA (Social Security and Medicare), and most state and local income taxes are calculated. As a result, You pay less taxes because taxes are based on less money. Premiums/contributions for coverage for You and Family Members who You may claim as dependents for tax purposes (other than Committed Partners and Your Committed Partner's Child) are deducted from Your pay on a before-tax basis (except that retroactive premiums will be deducted on an after-tax basis) for the following BenefitsPlus programs: Medical; Dental; Vision; Health Care FSA; Dependent Care FSA; and HSA.

- **After-tax premiums/contributions** are deducted from Your pay after federal income, FICA (Social Security and Medicare) and most state and local income taxes are calculated. Premiums/contributions are deducted on an after-tax basis for the Regular Plan and the following BenefitsPlus Programs: Optional Life Insurance; AD&D; Spouse/Child Life Insurance; and Optional Long Term Disability.

- To comply with Federal law, the amount you pay before-tax for coverage for your Committed Partner and Children of your Committed partner and the value of coverage for Your Committed Partner and children of Your Committed Partner that exceeds the amount You pay for Your coverage will be imputed to Your income. If Your state permits pre-tax deductions for this coverage, then you may recover any over withholding on Your state income tax return.

- Premiums/contributions for the Plan are paid on an after-tax basis if made in any form other than payroll deduction.

WHEN COVERAGE BEGINS

GENERAL INFORMATION: Generally, coverage begins the first day after You complete Your eligibility period. Coverage will not begin if:

—You are not eligible to participate;
—You and Your Family Members are not properly enrolled;
—You have not made a required contribution for coverage;
—Your Family Member's eligibility documentation has not been received and verified; or
—If the limitations described below apply.

- If a separate eligibility period is required for Family Members, then coverage for Your Family Members begins the first day after You complete the Family Members eligibility period.

- For each Plan Year following the completion of Your eligibility period, coverage begins on January 1 following the annual enrollment period; however, **if a Statement of Health (SOH) was required,** and (i) coverage was approved prior to January 1, then coverage begins on January 1 following the annual enrollment period or (ii) coverage was approved after January 1, then coverage begins on the date of approval.

- All valid elections will be effective January 1 of the Plan Year (or the date you are eligible for coverage on the date coverage has been approved) through December 31 of the Plan Year (or the date You are no longer eligible).

LIMITATIONS:

- Your Family Members coverage cannot begin prior to the date Your coverage begins.

- When You and/or Your Family Members enroll due to a Qualified Life Event, coverage begins on the date of the Qualified Life Event provided You've completed required forms and submitted required eligibility documentation within the applicable required time frames.

- When You are on a leave of absence and when You return to work following a leave of absence, the date coverage begins may be affected. See the "Leave of Absence" section of this SPD.

- For the **Vision Program,** if You were not at work (whether or not You were scheduled to work) due to an injury, illness or pregnancy on the date before Your coverage would begin or increase, none of Your coverage will begin or increase until You return to Active Work.

- For certain Qualified Life Events, You may elect or increase Spouse/Child Life insurance coverage. All requirements of this "When Coverage Begins" section must be met. Coverage for Your newly Family Members will begin on the date each Family Member becomes eligible, subject to the additional rules in the "MidYear Changes to Enrollment or Eligiblity" and "Life/AD&D Insurance" sections of this SPD.

- For the **Life Insurance Program,** Basic Life coverage will begin 1 day after You complete the eligibility period, and Supplemental Life coverage, if elected within the required timeframe, will begin later of 1 day after You complete the eligibility period for the supplemental coverage and is not subject to evidence of insurability.

When Coverage Ends

Employee Coverage:

- **Your coverage ends on the earliest of the following dates:**
  - the date You are no longer eligible for coverage or Your participation ends;
  - the last day of the last period for which You made required contributions/premiums, except that coverage may continue under certain circumstances if You are on a leave of absence;
  - the day the Plan ends;
  - the day the Plan is terminated with respect to Your job or coverage classification;
  - for the Long Term Disability Plan only, the day You become a fulltime member of the armed forces of any country, except to the extent provided otherwise in this SPD;
  - the day You are no longer Actively at Work, except that coverage may continue under certain circumstances if You are on a leave of absence;
  - the day You are no longer Actively at Work because of a temporary layoff or general work stoppage (including a strike or lockout) resulting from a labor dispute; or
  - the day Your employment with Southwest ends.

- **For certain retirees, coverage for the Medical and Dental Programs may be continued.** If You are a noncontract Employee, refer to the retirement checklist on SWALife for additional information. For contract Employees, refer to Your collective bargaining agreement. Full payment of premiums during the continuation period is required. The continuation period will end on the later of (i) the period for which You could have elected COBRA continuation coverage (counting from the date Your employment with Southwest ends), or (ii) the date You attain age 65.

- **For the Long Term Disability Program only, Your coverage may be continued** during Your Benefit Waiting Period and while Monthly Long Term Disability benefits are payable, if Your coverage would have ended only because You are no longer Actively at Work and not by one of the above dates.

- **Your pre-tax deposits to a Spending Account end on the last day You receive pay; however,** You may continue to file claims through March 31 of the next Year but only for eligible charges You incur through the date Your coverage ended.

Family Member Coverage:

- **Your Family Member coverage ends on the earliest of the following dates:**
  - the day the Employee's coverage or participation ends as described above;
  - the day a Family Member is no longer eligible for coverage including the day Your Committed Partner ceases to be eligible as described in the Partner Policy; or
  - the day the Plan is terminated with respect to all covered Family Members or to covered Family Members in one or more classifications including the covered Family Member in question.

- For the Medical; Dental; and Vision Programs only, Your Family Member coverage may be continued by Southwest for up to three Months for Covered Family Members of a deceased Employee if the Employee's death occurred while the Employee was covered under the Plan. This three Month period runs concurrently with any COBRA continuation period of the Covered Family Member.

- For Spouse Life, Committed Partner Life, and Child Life, coverage may be continued after the death of the Employee for a period of five Months.

COBRA Continuation Coverage: If Your coverage under the Plan ends, You or Your covered Family Members, other than Your Committed Partner and Your Committed Partner's children, may be eligible to continue coverage under the Medical, Dental, Vision, or Health Care FSA Programs under the provision of a Federal law called COBRA. For additional information regarding COBRA, see the "Your Rights Under COBRA" section of this SPD. In certain circumstances, although not required by Federal law, Southwest may provide continuation coverage similar to COBRA for Your Committed Partner and Your Committed Partner's children. Please refer to the Partner Policy for additional information.

Converting Coverage: If Your Life Insurance coverage ends, You may be able to port/convert to individual coverage under a separate group policy maintained by the insurance carrier. See the Life Insurance/AD&D Insurance Program section of this SPD for additional information.

MIDYEAR CHANGES TO ENROLLMENT AND ELECTIONS

GENERAL INFORMATION: The IRS dictates that You may not change Your benefits enrollment or elections unless You have Qualified Life Event. You may make a qualified Change in Status/Special Enrollment to the extent that section 125 of the Internal Revenue Code, as amended from time to time, and corresponding guidance allow. To the extent there are any contradictions between this Section of this SPD and section 125 of the Internal Revenue Code, then the section 125 provisions prevail.

- **Committed Partners and Committed Partners' Children are not considered Family Members for purposes of determining Qualified Life Events.**

DEADLINES FOR ELIGIBLE MIDYEAR CHANGES: **You must submit a signed and dated qualified Life Event Form available at SWALife>About Me and all required documentation within 30 days after the date of the Qualified Life Event (60 days if related to Medicaid/CHIP).** If documentation cannot be provided within the 30 day period as required by the Plan Administrator, You must contact the Health & Wellness Team within the 30 day eligibility period and submit in writing a request for an extension. If the request is approved, the period for submitting documentation will be extended an additional 15 days. If You do not return the required form and documentation within 30 days, within 45 days if Your request for an extension was approved, or within such longer time as required by law, then You may not enroll Your Family Member until the next annual enrollment period, unless You have another qualifying event.

- If You notify the Health & Wellness Team within 30 days (60 days if related to Medicaid/CHIP) and documentation is provided within 30 days (60 days for Medicaid/CHIP) after the date of the qualifying event:
  - and You are **adding coverage**, then You and/or Your newly Family Member will be added effective as of the date of the Qualified Life Event; or
  - if You are **dropping coverage**, then ineligible individuals will be dropped effective as of the date of the Qualified Life Event or loss of eligibility under the Plan.

- If You notify the Health & Wellness Team more than 30 days after the date of the qualifying event (60 days if related to CHIP) and:
  - You are **adding coverage**, and if You fail to provide all required documentation, then You may not enroll Your newly Family Member until the next annual enrollment period, unless You have another Qualified Life Event; or
  - You are **dropping coverage**, then You and/or Your Family Member who is no longer eligible for coverage will be dropped effective as of the date eligibility for coverage ceased and You will **not** receive a refund of premiums paid for the period after the effective date coverage is dropped, even though You and/or Your inFamily Member were not eligible for benefits under the Plan. You must also repay the Plan for any benefit claim overpayments made by the Plan.

NEWBORN ELIGIBILITY:

- If the Employee notifies the Health & Wellness Team within 30 days of the birth/adoption, the child can be added on a pre-tax basis retroactive to the date of the birth/adoption.
- If the Employee notifies the Health & Wellness Team after 30 but within 90 days of the birth/adoption, the child can be added on a pre-tax basis as of the date the Health & Wellness Team is notified (i.e., no retroactive coverage).
- If the Employee notifies the Health & Wellness Team after 90 days of the birth/adoption, then the child cannot be added until the following annual enrollment.

- In all cases above, **You must repay the Plan for any benefit claim overpayments made by the Plan.** If You are eligible to receive a refund amount for contributions and/or extra pay, You will receive the difference between the refunded amount, if any, and any benefit claim overpayments made by the Plan. If the overpayment exceeds the refund, You must repay the Plan any remaining overpayment amount.

CHANGE IN STATUS: A Change in Status includes and is limited to the events listed below. For most Qualified Life Events, You may only change Your Family Member level of coverage. You may only add or delete Your Program options for the events listed in bold and only if You elected "No Medical" or "No Dental" coverage.

- **You get married to a Spouse.**
- You and Your Spouse get divorced or legally separated,
- **You add a child through birth, adoption, or placement for adoption,**
- Your Family Member otherwise becomes eligible for coverage (including pursuant to a court order),
- Your Family Member is no longer eligible for coverage due to death, age, marriage, cessation of disability, or non-fulltime student status,
- **You, Your Spouse, or another Family Member experiences a significant change in coverage or the cost of coverage under the plan of Your Spouse's employer or Family Member's employer (this means a change that results in Your Spouse or other eligible Family member being eligible to elect or change coverage under the other employer's plan, due to a significant curtailment of coverage, loss of coverage, change in the cost of coverage, or improvement in coverage, as determined by the Plan Administrator),**
- You and/or Your Family Member(s) receive other coverage due to employment, a new work schedule or classification, or a change in residence or worksite,

- **You and/or Your Family Member(s) lose other coverage due to employment termination, a strike or lockout, a new work schedule or classification, or a change in residence or worksite,**
- You and/or Your Family Member becomes entitled to Medicare or Medicaid,
- You change from Parttime to Fulltime status or from Fulltime to Parttime status,
- You take an eligible leave of absence (only applies to certain types of leave of absence),
- **You or Your Spouse is required to provide coverage for Your child pursuant to a qualified medical child support order,**
- Your Spouse or Family Member changes a coverage election under the plan of the Spouse's employer or Family Member's employer for a period of coverage that is different from the Calendar Year period of coverage of the Plan.
- Your Spouse or Family Member loses coverage under a group health plan sponsored by a governmental or educational institution (such as CHIP or a State health benefits risk pool),

MID-YEAR COVERAGE CHANGES FOR COMMITTED PARTNERS: Committed Partners and Committed Partner's children are not considered Family Members for purposes of Change in Status or Special Enrollment; however, You may drop Your Committed Partner or Your Committed Partner's children from coverage at any time including at annual enrollment. You must drop coverage for Your Committed Partner's children if You drop coverage for Your Committed Partner.

- **In addition, You must drop Your Committed Partner and Your Committed Partner's children from coverage by providing written notice to the Health & Wellness Team within 30 days after dissolution of Your committed partnership, death of Your Committed Partner, the date Your Committed Partner ceases to be eligible, or the date Your Committed Partner receives or becomes eligible to receive other employer sponsored group health coverage.** Your Committed Partner and Your Committed Partner's children cease to be eligible on the date of any such event even if You do not drop him/her within 30 days of the event. If You drop Your Committed Partner and Your Committed Partner's children after 30 days following the event, You will only receive a refund of premiums/contributions for coverage from the date Your written request to drop Your Committed Partner and Your Committed Partner's children is received. You must also repay any Medical and Dental benefits that were paid for claims incurred by Your Committed Partner or Your Committed Partner's children after the date eligibility ended. In most cases, if You drop a Committed Partner or a Committed Partner's children from coverage, You may not reenroll that Committed Partner or that Committed Partner's children or enroll a new Committed Partner for a period of 12 Months.
- If a Committed partner is added to coverage mid-Year, You may purchase additional Optional Life or AD&D coverage for Employee only (with approved Statement of Health).

SPECIAL ENROLLMENT: If You are eligible for coverage under the Medical and Dental Programs, but elect "No Medical" coverage or "No Dental" coverage during the new Employee enrollment period or any subsequent annual enrollment because You and Your Family Member have other coverage, and You or an Family Member subsequently loses that other coverage including exhaustion of COBRA continuation coverage, then You and Your Family Member who lose coverage will be allowed to enroll in BenefitsPlus Medical and Dental programs during a Special Enrollment period if certain conditions are satisfied.

- This Special Enrollment opportunity applies to all Family Members who are eligible, but not enrolled, for coverage under the Plan. This Special Enrollment period ends **30 days** after the loss of qualifying coverage.

- Loss of eligibility does not include a loss of coverage due to a failure to timely pay premiums, or a termination of coverage for cause (such as for making a fraudulent claim). Loss of eligibility includes a loss of coverage due to the following:
  - legal separation, divorce, death, termination of employment, cessation of dependent status, or reduction in hours of employment; and
  - claims are incurred in excess of lifetime benefit limits.

CHART OF ALLOWED CHANGES FOR CHANGE IN STATUS/SPECIAL ENROLLMENT:

The following chart provides some examples of Qualified Life Events and the general options for changes in coverage that may be available to You following these events. The change must be on account of, and correspond with, the Change in Status. Whether You are in fact entitled to make these changes under this rule depends on the facts and circumstances. (For example, becoming married normally is only consistent with adding coverage for Your new Spouse and not consistent with dropping Your own coverage; however, if due to the marriage, You become covered under Your Spouse's employer group health plan, then dropping Your coverage would be consistent with your marriage and permitted). Your change in coverage must be consistent with Your Change in Status, and Southwest reserves the right to decline the change in coverage request if it is not consistent with the event. The following examples are illustrative only and not intended to guarantee that You can make the illustrated change.

CHART OF ALLOWED CHANGES FOR CHANGE IN STATUS/SPECIAL ENROLLMENT

	EVENT				
	You Get Married	**You Get Divorced or Legally Separated**	**Birth or Adoption or Placement for Adoption of Child**	**Child Otherwise Becomes Eligible for Coverage**	**Spouse or Child Dies**
Medical	You may add newly Family Members to existing coverage, or You and Your newly Family Members may change from "No Medical" coverage to BenefitsPlus. You may also drop coverage or drop Family Members if coverage is effective or increased under another plan.	Your Spouse and stepchildren must be dropped from coverage. You and Your Family Members may be eligible for Special Enrollment if You lose coverage as a result of the divorce or legal separation. You may also add coverage or add a Family Member if coverage is lost under Your Spouse's plan.	You may add only the new child and Your Spouse to existing coverage, or You, Your Spouse, and the new child may change from "No Medical" coverage to BenefitsPlus.	You may add only the newly eligible child to existing coverage, or You, Your Spouse, and the new child may change from "No Medical" coverage to BenefitsPlus.	You may drop Your deceased Family Members from coverage. You and Your Family Members may be eligible for Special Enrollment if You lose coverage as a result of the death. You may also add coverage or add a Family Member if coverage is lost under Your Spouse's plan.
Dental	You may add newly Family Members to existing coverage, or You and Your newly Family Members may change from "No Dental" coverage to BenefitsPlus Basic or Optional coverage. You may also drop coverage or drop Family Members if coverage is effective or increased under another plan.	Your Spouse and stepchildren must be dropped from coverage. You and Your Family Members may be eligible for Special Enrollment if You lose coverage as a result of the divorce or legal separation. You may also add coverage or add a Family Member if coverage is lost under Your Spouse's plan.	You may add only the new child and Your Spouse to existing coverage or You, Your Spouse, and the new child may change from "No Dental" coverage to BenefitsPlus Basic or Optional coverage.	You may add only the newly eligible child to existing coverage.	You may drop Your deceased Family Members from coverage. You and Your Family Members may be eligible for Special Enrollment if You lose coverage as a result of the death. You may also add coverage or add a Family Member if coverage is lost under Your Spouse's plan.
Vision	You may add newly Family Members to existing coverage. You may also drop coverage or drop Family Members if coverage is effective or increased under another plan.	Your Spouse and stepchildren must be dropped from coverage. You may also add coverage or add a Family Member if coverage is lost under Your Spouse's plan.	You may add the new child and Your Spouse to existing coverage, or You may add coverage for your Family Members if You previously had no coverage.	You may add only the newly eligible child to existing coverage.	You may drop only Your deceased Family Members from coverage. You may also add coverage or add a Family Member if coverage is lost under Your Spouse's plan.
Health Care FSA	You may increase coverage.	You may decrease coverage.	You may increase coverage.	You may increase coverage.	You may decrease coverage.
Dependent Care FSA	You may decrease or eliminate deposits if the new Spouse is providing dependent care to Family Members or to the extent required to comply with the earned income contribution limitations.	You may decrease or eliminate deposits if the dropped child is the only Family Member eligible. You may also increase or add contributions to the extent Your Spouse formerly provided dependent care to Your children and You will now incur increased costs for dependent care.	You may add or increase deposits.	You may add or increase deposits.	You may decrease or eliminate deposits if the dropped child(ren) are the only Family Members eligible.
Basic or Optional Life	You may elect one level or increase one level of Optional Life insurance. For additional levels of Optional Life insurance, You must provide Statement of Health, and the insurance carrier must approve the elected amount.	You may decrease or drop coverage.	See last page of this Section.	You may elect one level or increase one level of Optional Life insurance. For additional levels of Optional Life insurance, You must provide Statement of Health, and the insurance carrier must approve the elected amount.	You may decrease or drop coverage.
AD&D	You may elect or increase to any level. You may also drop or decrease coverage in some cases.	You may drop or decrease coverage. You may also add or increase coverage in some cases.	You may elect or increase to any level.	You may elect or increase to any level.	No change
Child Life	You may elect or increase to any level.	You may drop coverage if You have no other eligible children .	See last page of this Section.	You may elect to add the new child Family Members to any level of coverage.	You may drop coverage if You have no other eligible children.
Spouse Life	You may elect or increase to the $10,000 or $20,000 coverage level. For additional levels, You must provide Statement of Health (EOI), and the insurance carrier must approve the elected amount.	Your Spouse's coverage must be dropped.	You may elect or increase to the $10,000 or $20,000 coverage level. For additional levels, You must provide Statement of Health (EOI), and the insurance carrier must approve the elected amount.	You may elect or increase to the $10,000 or $20,000 coverage level. For additional levels, You must provide Statement of Health (EOI), and the insurance carrier must approve the elected amount.	Your deceased Spouse's coverage must be dropped
Basic or Optional LTD	No change	No change	No change	No change	No change

CHART OF ALLOWED CHANGES FOR CHANGE IN STATUS/SPECIAL ENROLLMENT (CONTINUED)

	Event				
	Child Loses Eligibility Under the Plan	**Significant Adverse Change in Eligible Family Members(s) Coverage or Cost of Coverage Under Other Employer's Plan**	**Special Enrollment Due to Loss of Eligibility for Other Coverage[1] or Exhaustion of COBRA Coverage**	**You and/or Family Members Receives Other Coverage Due to New Employment, Work Schedule or Classification, or Residence/Work Site or Family Members's Other Coverage or Cost of Coverage is Significantly Improved**	**You and/or Family Members Loses Other Coverage Due to Employment Termination, Strike or Lockout, Work Schedule or Classification, or Residence/Work Site**
Medical	You may drop the ineligible child(ren) from coverage.	You may add Your affected Family Members to existing coverage, or You and Your affected Family Members may change from "No Medical" coverage to BenefitsPlus.	You may add Family Members who lose coverage to existing coverage, or You and Your Family Members who lose coverage may change from "No Medical" coverage to BenefitsPlus.	You may drop coverage for the Family Members(s) who receives new coverage (and for Yourself if You receive new coverage).	You may add Your affected Family Members to existing coverage, or You and Your affected Family Members may change from "No Medical" coverage to BenefitsPlus.
Dental	You may drop the ineligible child(ren) from coverage.	You may add Your affected Family Members to existing coverage, or You and Your affected Family Members may change from "No Dental" coverage to BenefitsPlus Basic or Optional coverage, if due to the change of other dental coverage.	You may add Family Members who lose coverage to existing coverage, or You and Your Family Members who lose coverage may change from "No Dental" coverage to BenefitsPlus Basic or Optional coverage.	You may drop coverage for the Family Members(s) who receives new coverage (and for Yourself if You receive new coverage).	You may add Your affected Family Members to existing coverage, or You and Your affected Family Members may change from "No Dental" coverage to BenefitsPlus Basic or Optional Dental coverage if due to the change of other dental coverage.
Vision	You may drop the ineligible child(ren) from coverage.	You may add Your affected Family Members to existing coverage.	No change	You may drop coverage for the Family Members(s) who receives new coverage (and for Yourself if You receive new coverage).	You may add Your affected Family Members to existing coverage, or You may add new coverage if coverage was lost.
Health Care FSA	You may decrease deposits corresponding to Your child's loss of coverage.	No change	In some cases, You may increase deposits in the event that a loss of eligibility under Your Spouse's plan results in an addition of Family Members under this Plan.	No change	In some cases, You may increase deposits in the event that a loss of eligibility under Your Spouse's plan results in an addition of Family Members under this Plan.
Dependent Care FSA	You may decrease or eliminate deposits if the dropped child(ren) are the only Family Members eligible.	You may increase or decrease Your deposits to correspond to certain changes in dependent care, such as a change in dependent care providers, a cost change imposed by a dependent care provider who is not a relative, a reduction in the hours of dependent care required (e.g., for a child who is entering school and now needs fewer hours of care each week).	No change	You may decrease or eliminate deposits if the change is on account of and consistent with You or Your Spouse's new employment, work schedule, or worksite. You may also add coverage or increase Your deposits if Your Spouse previously was providing dependent care to eligible Family Members and will begin working and this necessitates new dependent care expenses.	You may decrease or eliminate deposits if the change is on account of and consistent with Your Spouse's termination of employment or reduction in hours worked, or new work schedule or worksite, and Your Spouse is providing dependent care to Family Members.
Basic or Optional Life	No change	No change	No change	You may increase or decrease Optional Life coverage to the extent coverage is lost or gained (respectively) under the other plan.	You may increase or decrease Optional Life coverage to the extent coverage is lost or gained (respectively) under the other plan.
AD&D	No change	No change	No change	You may increase or decrease coverage to the extent coverage is lost or gained (respectively) under the other plan.	You may increase or decrease coverage to the extent coverage is lost or gained (respectively) under the other plan.
Child Life	You may drop coverage if You have no other eligible children.	No change	No change	No change	No change
Spouse Life	No change	No change	No change	No change	No change
Basic or Optional LTD	No change	No change	No change	No change	No change

(1) Other Coverage includes coverage that You have under the Transitional Assistance Management Program (TAMP) that runs out after Your return from military leave.

CHART OF ALLOWED CHANGES FOR CHANGE IN STATUS/SPECIAL ENROLLMENT (CONTINUED)

	Event				
	Entitlement to Medicare or Medicaid	You Change from Parttime to Fulltime	You change from Fulltime to Parttime	You Take FMLA or Military Leave (See the "Leave of Absence" section of this SPD for other Special Leave Rules)	Qualified Medical Child Support Order (QMCSO)
Medical	You may drop coverage for Yourself and any Family Members who become entitled to Medicare or Medicaid.	You may add Family Members to Your existing coverage.	You may drop Family Members from Your existing coverage.	You may drop coverage for Yourself and Your Family Members, and You may reinstate coverage upon returning from FMLA leave.	You may add the affected children if You are required to provide coverage. If You elected No Medical coverage, You may also change to any BenefitsPlus medical option [1]. You may drop the affected children if Your Spouse is required to provide coverage. You may also change Programs as indicated in the QMCSO.
Dental	No change	You may add Family Members to Your existing coverage.	You may drop Family Members from Your existing coverage.	You may drop coverage for Yourself and Your Family Members and reinstate coverage upon returning from FMLA leave.	You may add the affected children if You are required to provide coverage. If You elected No Dental coverage, You may also change to any BenefitsPlus dental option [1]. You may drop the affected children if Your Spouse is required to provide coverage. You may also change Programs as indicated in the QMCSO.
Vision	No change	No change	No change	You may drop coverage for Yourself and Your Family Members and reinstate coverage upon returning from FMLA leave.	You may add the affected children if You are required to provide coverage. If You elected No Vision coverage, You may also change to any BenefitsPlus vision option [1]. You may drop the affected children if Your Spouse is required to provide coverage. You may also change Programs as indicated in the QMCSO.
Health Care FSA	You may decrease deposits if You drop medical coverage under the Plan as a result of Medicare entitlement.	You may increase deposits if You add medical coverage for Family Members under the Plan as a result of Your change in employment status.	You may decrease deposits if You drop eligible Family Members from Your existing medical coverage under the Plan as a result of Your change in employment status.	You may eliminate deposits and reinstate deposits after returning from leave.	You may increase deposits if You add medical coverage for any Family Members under the Plan as a result of a QMCSO.
Dependent Care FSA	No change	You may increase deposits if You were previously providing dependent care to eligible dependents and Your change in employment status necessitates a new dependent care provider.	You may decrease deposits if the change is on account of and consistent with Your new work schedule.	You may decrease or eliminate deposits for the remainder of that Calendar Year. (This rule applies to all leaves of absence.)	No change
Basic or Optional Life	No change	No change	No change	You may drop coverage and reinstate coverage upon return from leave.	No change
AD&D	No change	No change	No change	You may drop coverage and reinstate coverage upon return from leave.	No change
Child Life	No change	No change	No change	You may drop coverage and reinstate coverage upon return from leave.	No change
Spouse Life	No change	No change	No change	You may drop coverage and reinstate coverage upon return from leave.	No change
Basic or Optional LTD	No change	No change	No change	You may drop coverage and reinstate coverage upon return from leave.	No change

[1] If You currently have no medical option elected and a qualified medical child support order is received by the Health & Wellness Team, and You haven't submitted a Life Event Form, then You and the court ordered dependent(s) will automatically be enrolled into the BenefitsPlus Choice Plus Plan medical option, and, if required by the qualified medical child support order, the BenefitsPlus Basic Dental Program and Vision Program.

CHART OF ALLOWED CHANGES FOR MARRIED SOUTHWEST EMPLOYEES—MARRIAGE

	When You Marry A Southwest Employee and Both Employees are Enrolled in BenefitsPlus	When You Marry A Southwest Employee and One Employee is Enrolled in the Regular Plan and the Other Employee is Enrolled in BenefitsPlus	When You Marry a Southwest Employee and You and Your Spouse are Enrolled in the Regular Plan
In General	Either Employee may become the "primary Spouse." However, if only one of You is a Fulltime Employee, the Fulltime Employee will automatically be the primary Spouse. The primary Spouse will maintain payroll deductions for coverage of all covered Family members (including the other Employee) under most BenefitsPlus options.	The Employee who is enrolled in BenefitsPlus will be the "primary Spouse." However, if the Employee with BenefitsPlus coverage is Parttime and the Employee with Regular Plan coverage is Fulltime, the Fulltime Employee will automatically be the primary Spouse and will continue the BenefitsPlus coverage of the Parttime Employee, except as described below. The primary Spouse will maintain payroll deductions for coverage of all covered Family Members (including the other Employee) under most BenefitsPlus options.	You, Your Spouse, and Your other Family Members will be covered under the Regular Plan. Both Employees must retain their original Life, LTD and Child Life elections for the remainder of the Year in which the marriage occurs.
Medical	You, Your Spouse and Your other Family Members must be covered under the same Medical Program. You may choose between the two existing options in which You and Your Spouse are enrolled. The primary Spouse will be responsible for payroll deductions.	You, Your Spouse and Your other Family Members must be covered under the BenefitsPlus Medical Program which the Employee who had BenefitsPlus had elected. The primary Spouse will be responsible for payroll deductions.	You, Your Spouse, and Your other Family Members must be covered under the Regular Plan. Claims will be processed under one Employee's Social Security Number (the primary Spouse). If You do not specify which Employee is the primary Spouse, the male Employee's Social Security Number/Alternate ID Number will be used.
Dental	You, Your Spouse and Your other Family Members must be covered under the same Dental Program. If either one of You have Dental Coverage; then dental coverage must be continued by the primary Spouse. If You and Your Spouse are covered under different Dental Programs; then the higher coverage option (Optional Dental Program over the Basic Dental Program) must be continued by the primary Spouse.	You, Your Spouse and Your other Family Members must be covered under the previously elected BenefitsPlus option. If the Employee who had BenefitsPlus had "No Dental" coverage, the BenefitsPlus Basic Dental Program may be added. The primary Spouse will be responsible for payroll deductions.	You, Your Spouse, and Your other Family Members must be covered under the Regular Plan. Claims will be processed under one Employee's Social Security Number (the primary Spouse). If You do not specify which Employee is the primary Spouse, the male Employee's Social Security Number or alternate ID will be used.

CHART OF ALLOWED CHANGES FOR MARRIED SOUTHWEST EMPLOYEES—MARRIAGE (CON'T.)

	When You Marry A Southwest Employee and Both Employees are Enrolled in BenefitsPlus	When You Marry A Southwest Employee and One Employee is Enrolled in the Regular Plan and the Other Employee is Enrolled in BenefitsPlus	When You Marry a Southwest Employee and You and Your Spouse are Enrolled in the Regular Plan
Vision	If both You and Your Spouse have Vision coverage, the coverage must be continued by the primary Spouse at the Employee + Family coverage level. If one of You have Vision coverage, the coverage must be continued if the Spouse with coverage has Employee + Family coverage; then Employee + Family coverage must be continued by the primary Spouse and will include the other Spouse. If the Spouse with coverage has Employee Only coverage; then Vision coverage may be changed to Employee + Spouse or Employee + Family coverage or remain Employee Only coverage with benefits available only to the Employee with coverage for the remainder of the Calendar Year. Thereafter, the primary Spouse must carry the Vision coverage for the family.	If both You and Your Spouse have Vision coverage, the coverage must be continued as originally elected and may not be changed until the next annual enrollment. If one of You have Vision coverage, the coverage must be continued by the Employee who has coverage as follows: If the Employee with coverage has BenefitsPlus coverage: Vision coverage must be continued under BenefitsPlus. If Employee+Family coverage was elected, it must be continued and will include the other Spouse. If Employee Only coverage was elected, the level of coverage may be changed to Employee+Family coverage or remain Employee Only coverage with no benefits for the other Employee. If the Employee with coverage had Regular Plan coverage: Vision coverage will be changed to the BenefitsPlus Plan. If Employee+Family coverage was elected, the primary Spouse will carry Vision coverage for all Family Members. If Employee Only coverage was elected, the level of coverage may be changed to Employee+Family coverage under the primary Spouse or remain Employee Only coverage under the dependent Spouse with no benefits for the Employee for the remainder of the Calendar Year. Thereafter, the primary Spouse must carry all Vision coverage for the family.	If both You and Your Spouse have Employee Only Vision coverage: The coverage must be continued by You and Your Spouse. If both You and Your Spouse have Employee+Family Vision coverage, only one Employee may carry coverage for all of the Family Members. If only one of You has Vision coverage, the coverage must be continued as follows: If the Employee with coverage has Employee+Family coverage: Employee+Family coverage must be continued and will include the other Spouse. If the Employee with coverage has Employee Only coverage: Vision coverage may be changed to Employee+Family coverage or remain Employee Only coverage with benefits available only to the Employee with coverage.
Health Care FSA	Contributions will continue separately as originally elected by You and Your Spouse. No changes may be made until the next annual enrollment.	Contributions will continue under the primary Spouse as originally elected by the Employee in BenefitsPlus. No changes may be made until the next annual enrollment.	Coverage will continue as originally elected by each Employee. Each Employee will continue to maintain separate payroll deductions for the coverage elected.
Dependent Care FSA	If both You and Your spouse are currently making contributions, the contribution amounts may either be combined and carried by the primary Spouse, or remain as separate elections to be carried by each Employee. However, the total combined amount You and Your Spouse may contribute cannot exceed $5,000 during the Year.	Contributions will continue under the primary Spouse as originally elected by the Employee in BenefitsPlus. No changes may be made until the next annual enrollment. However, the total combined amount You and Your Spouse may contribute cannot exceed $5,000 during the Year.	Coverage will continue as originally elected by each Employee. Each Employee will continue to maintain separate payroll deductions for the coverage elected.
Basic or Optional Life/ AD&D/Basic or Optional LTD	Coverage will continue as originally elected by You and Your Spouse. Each Employee will continue to maintain separate deductions for the coverage elected. No changes may be made until the next annual enrollment.	The Employee with BenefitsPlus coverage may not make any changes to his or her coverage. The Employee with Regular Plan coverage must port/convert his or her Regular Plan coverage to comparable levels of coverage under BenefitsPlus. Each Employee will continue separate deductions for coverage.	Both Employee's must retain their original Life, AD&D, and LTD elections.
Child Life	If either or both of You have Child Life coverage, coverage will be continued under BenefitsPlus by either Employee but not both for all Family Members. No child may be covered under Child Life by more than one Employee.	If either or both of You have Child Life coverage, coverage as originally elected by the Employee with BenefitsPlus will be continued under the BenefitsPlus Plan by the primary Spouse. No child may be covered under Child Life of more than one Employee.	If either or both of You have Child Life coverage, coverage will be continued by one of You for any eligible child Family Members. No child may be covered under Child Life of more than one Employee.
Spouse Life	You may not insure Your Employee Spouse under Spouse Life.	You may not insure Your Employee Spouse under Spouse Life.	If either or both of You have Child Life coverage, coverage will be continued by one of You for any eligible child Family Members. No child may be covered under Child Life of more than one Employee.

CHART OF ALLOWED CHANGES FOR MARRIED SOUTHWEST EMPLOYEES—DIVORCE (CONTINUED)

	When You Divorce a Southwest Employee and You and Your Spouse are Both Enrolled in BenefitsPlus	When You Divorce a Southwest Employee and You and Your Spouse are Both Enrolled in the Regular Plan
In General	Medical, Dental, and Vision coverage will be continued under both Employees. No changes may be made to Optional LTD, Optional Life, Child Life or AD&D.	Medical, Dental and Vision coverage will be continued under both Employees, if eligible.
Medical and Dental	Both of You must continue all existing coverage. It is Your responsibility to determine which parent will continue to cover Your other Family Members. A stepparent is not eligible to cover stepchildren after divorce.	Both of You must continue all existing coverage. It is Your responsibility to determine which parent will continue to cover Your other Family Members. A stepparent is not eligible to cover stepchildren after divorce.
Vision	Both of You must continue all existing coverage. It is Your responsibility to determine which parent will continue to cover Your other Family Members. A stepparent is not eligible to cover stepchildren after divorce.	Vision coverage must be continued as originally elected before the divorce. However, only Aircraft Appearance Technicians, Customer Service Agents, Dispatchers, Flight Simulator Technicians, Mechanics, Pilots, Customer Representatives and Stock Clerks are eligible to continue coverage. It is Your responsibility to determine which parent will continue to cover Your other Family Members.
Health Care FSA	The original contribution must be continued by either of You or divided and contributed by both. You may not make any other changes until the next annual enrollment.	Not Available
Dependent Care FSA	The original contribution must be continued by either of You ... this is determined by whoever assumes primary custody of the qualifying dependents or the parent with whom the qualifying dependents principally reside if custody is joint. You may not make any other changes until the next annual enrollment.	Not Available
Basic or Optional Life/ AD&D/Basic or Optional LTD	Coverage will continue as originally elected by each Employee. Each Employee will continue to maintain separate payroll deductions for the coverage elected.	Coverage will continue as originally elected by each Employee. Each Employee will continue to maintain separate payroll deductions for the coverage elected.
Child Life	If either of You had coverage before the divorce, then it must be continued by either You or Your Spouse. It is Your responsibility to decide who will continue to carry Child Life on Your eligible child Family Members.	For Child Life, only one Employee may continue Child Life for eligible child Family Members. It is Your responsibility to determine which parent will continue Child Life coverage.
Spouse Life	You are not eligible for Spouse Life.	You are not eligible for Spouse Life.

CHART OF ALLOWED CHANGES FOR MARRIED SOUTHWEST EMPLOYEES—TERMINATION

	When You Terminate Employment at Southwest and You and Your Spouse are Both Enrolled in BenefitsPlus	When You Terminate Employment at Southwest and You and Your Spouse are Both Enrolled in the Regular Plan
In General	Benefits for certain coverage will be continued under the Spouse who remains a Southwest Employee.	Benefits for certain coverage will be continued under the Spouse who remains a Southwest Employee.
Medical and Dental	Your Spouse and any Family Members covered at the time of Your termination will continue in the same plans in effect at the time of Your termination. You will become a dependent of Your Spouse. Your Spouse will assume all payroll deductions associated with the continued coverage through the end of the Calendar Year in which You terminated. No other changes may be made until the next annual enrollment.	Your Spouse and any Family Members covered at the time of Your termination will continue the same plans in effect at the time of Your termination. You will become a dependent of Your Spouse.
Vision	If You were enrolled in Employee Only Vision coverage before Your termination: Your Spouse may change to Employee+Spouse or Family Vision coverage. If Employee +Spouse or Family coverage is elected, Your Spouse will assume all responsibilities for payroll deductions associated with continuing this level of Vision coverage through the end of the Calendar Year in which Your termination occurred. You will become a dependent of Your Spouse. If You wish to continue Employee Only Vision coverage, You may do so by electing COBRA. Special conditions will apply. For additional information regarding COBRA, see the "Your Rights Under COBRA" section of this SPD. If You were enrolled in Employee+Family coverage before Your termination: Your Spouse must continue that level of Vision coverage through the end of the Calendar Year in which You terminated. Your Spouse will assume all responsibilities for payroll deductions associated with continuing this level of Vision coverage through the end of the Calendar Year in which termination occurred. You will become a dependent of Your Spouse.	If You were enrolled in Employee Only Vision coverage before Your termination: Your Spouse may change to Employee+Family Vision coverage as long as he or she is classified as a Aircraft Appearance Technician, Customer Service Agent, Dispatcher, Flight Simulator Technician, Mechanic, Pilot, Reservation Agent or Stock Clerk. Your Spouse will assume all responsibilities for payroll deductions associated with continuing this level of Vision coverage through the end of the Calendar Year in which termination occurred. You will become a dependent of Your Spouse. If Your Spouse is not eligible to continue Vision coverage (due to job classification), all covered individuals may continue Vision coverage under COBRA. For additional information regarding COBRA, see the "Your Rights Under COBRA" section of this SPD.
Health Care FSA	If You were contributing to the Account at the time of Your termination, Your Spouse will assume all responsibilities for payroll deductions associated with continuing these contributions through the end of the Calendar Year in which You terminated. You may not make any other changes until the next annual enrollment.	Not applicable
Dependent Care FSA	If You were contributing to the Account at the time of Your termination, Your Spouse will assume all responsibilities for payroll deductions associated with continuing these contributions through the end of the Calendar Year in which You terminated. Contributions may only be decreased or eliminated if the change is on account of and consistent with Your termination of employment and You are providing dependent care to Family Members.	Not applicable
Basic or Optional Life, AD&D, Basic or Optional LTD,	Your coverage will end at midnight on the date of Your termination. For information regarding conversion (Life and LTD) and Portability (Life) policies, see the "Life/AD&D Insurance" and "Long Term Disability" sections of this SPD.	Your coverage will end at midnight on the date of Your termination. For information regarding conversion policies, see the "Life/AD&D Insurance" and "Long Term Disability" sections of this SPD.
Child Life	If You were enrolled in Child Life before Your termination, the Child Life must be continued by Your Spouse. Your Spouse will assume payroll deductions for continuing this coverage for eligible children until the end of the Calendar Year in which You terminated.	If You were enrolled with Child Life before Your termination, the Child Life must be continued by Your Spouse for eligible children. Your Spouse will assume payroll deductions for continuing this coverage until the end of the Calendar Year in which You terminated.
Spouse Life	Your Spouse may elect Spouse Life coverage for You upon Your termination.	Your Spouse may elect Spouse Life coverage for You upon Your termination.

CHART OF ALLOWED CHANGES FOR MARRIED SOUTHWEST EMPLOYEES—FULLTIME/PARTIME CHANGES

	When You and Your Spouse are Southwest Employees and Either You or Your Spouse Changes from Fulltime to Parttime	When You and Your Spouse are Southwest Employees and Either You or Your Spouse Changes from Parttime to Fulltime	When You and Your Spouse are Southwest Employees and One of You is Fulltime and the Other is Parttime and the Employee with the Fulltime Status Terminates
In General	The Fulltime Spouse will become the primary Spouse.	No change will occur if coverage is currently provided under the Fulltime Spouse.	The Parttime Spouse will become responsible for coverage.
Medical Dental, and Vision	The Fulltime Spouse will become the primary Spouse and will be responsible for maintaining payroll deductions for coverage of all covered Family Members.	The Fulltime Spouse will become the primary Spouse and will be responsible for maintaining payroll deductions for coverage of all covered Family Members.	The remaining Spouse and any eligible covered Family Members will continue the same plans in effect at the time of Your termination. You will become a dependent of the remaining Spouse. The remaining Spouse will be responsible for maintaining payroll deductions for coverage of all covered Family Members. If the remaining Spouse has not met the eligibility period for Parttime: Any Family Members may elect COBRA until the eligibility period has been met.
Health Care FSA	The Fulltime Spouse will become the primary Spouse and will be responsible for maintaining payroll deductions.	The Fulltime Spouse will become the primary Spouse and will be responsible for maintaining payroll deductions.	The remaining Spouse will be responsible for maintaining payroll deductions.
Dependent Care FSA	The Fulltime Spouse will become the primary Spouse and will be responsible for maintaining payroll deductions. Contributions may be decreased or eliminated.	The Fulltime Spouse will become the primary Spouse and will be responsible for maintaining payroll deductions.	The remaining Spouse will be responsible for maintaining payroll deductions. Contributions may be decreased or eliminated if the change is on account of and consistent with the Spouse's termination of employment and the Employee who terminated is providing dependent care to Family Members.
Basic or Optional Life, AD&D, Basic or Optional LTD	Coverage will continue as originally elected by each Employee. Each Employee will continue to maintain separate deductions for the coverage elected. No changes may be made until the next annual enrollment.	Coverage will continue as originally elected by each Employee. Each Employee will continue to maintain separate deductions for the coverage elected. No changes may be made until the next annual enrollment.	Your coverage will end at midnight on the date You terminate. For information regarding conversion (Life and LTD) and Portability (Life), see the "Life/AD&D Insurance" and "Long Term Disability" sections of this SPD. No changes can be made for the remaining Spouse until the next annual enrollment.
Child Life	If either of You have coverage, it may be continued by the primary Spouse for any eligible child.	If either of You have coverage, coverage may be continued by the primary Spouse for any eligible child.	If You were enrolled in Child Life before Your termination, the Child Life must be continued by the remaining Spouse for eligible children. The remaining Spouse will assume payroll deductions for continuing this coverage until the end of the Calendar Year in which You terminated.
Spouse Life	You may not insure Your Employee Spouse under Spouse Life.	You may not insure Your Employee Spouse under Spouse Life.	Your Spouse may elect Spouse Life coverage for You upon Your termination.

CHANGE IN STATUS RELATING TO BIRTH OR ADOPTION:

For purposes of the Life Insurance Program, the following rules apply.

▪ If You have a child or adopt a child You may modify Your **MEMBER AND SPOUSE LIFE INSURANCE** elections provided You notify the Health & Wellness Team and submit all required documentation in accordance with this SPD. The effective dates for changes are:

- If You notify the Health & Wellness Team within 30 days of the birth or adoption, then coverage is retroactive to the date of birth or adoption;
- If You notify the Health & Wellness Team after 30 days but within 90 days of the birth or adoption, then coverage is effective the date the Health & Wellness Team is notified;
- If You notify the Health & Wellness Team after 90 days of the birth or adoption, then the election will not be valid and You must wait to enroll the child until the next annual enrollment period.

▪ If You have a child or adopt a child You may modify Your **CHILD LIFE INSURANCE** elections provided You notify the Health & Wellness Team and submit all required documentation in accordance with this SPD. The effective dates for changes depend on a number of factors as described below.

- If You do not have a Child Life Insurance election in place at the time of the live birth of Your child, then Child Life coverage in the amount of $10,000 is automatically provided from the moment of live birth for a period of 30 days. If You want to extend this Child Life coverage past the initial 30 days or increase the Child Life coverage level to $20,000, then the effective dates for changes are:
  - If You notify the Health & Wellness Team within 30 days of the birth, then Your elections will be effective retroactively to the date of birth;
  - If You notify the Health & Wellness Team after 30 days but within 90 days of the birth, then Your elections will be effective as of the date the Health & Wellness Team is notified;
  - If You notify the Health & Wellness Team after 90 days of the birth, then the election will not be valid and You must wait to enroll the child until the next annual enrollment period.
- If You do not have a Child Life Insurance election in place at the time You adopt a child and You would like to elect coverage, then the effective dates of Your changes are:
  - If You notify the Health & Wellness Team within 30 days of the adoption, then Your elections will be effective retroactively to the date of adoption;
  - If You notify the Health & Wellness Team after 30 days but within 90 days of the adoption, then Your elections will be effective as of the date the Health & Wellness Team is notified;
  - If You notify the Health & Wellness Team after 90 days of the adoption, then the election will not be valid and You must wait to enroll the child until the next annual enrollment period.
- When a Member has Child Life Insurance coverage in effect for a prior child at the time of live birth or adoption of a subsequent child, then the child will be covered at the level previously elected effective as of the date of birth or adoption. If You want to increase the coverage level to $20,000, then the effective dates for changes are:
  - If You notify the Health & Wellness Team within 30 days of the birth or adoption, then Your elections will be effective retroactively to the date of birth or adoption;
  - If You notify the Health & Wellness Team after 30 days but within 90 days of the birth or adoption, then Your elections will be effective as of the date the Health & Wellness Team is notified;
  - If You notify the Health & Wellness Team after 90 days of the birth or adoption, then the election will not be valid and You must wait to enroll the child until the next annual enrollment period.

END OF SECTION

LEAVE OF ABSENCE

GENERAL INFORMATION: A leave of absence may affect Your participation in the Plan. If You take a leave of absence, Your continued coverage depends on:

- The type of leave You take,
- What Programs You are enrolled in before Your leave begins,
- If the type of Your leave changes before You return to work (such as Medical Leave to Personal Leave), and
- Whether or not Your leave of absence qualifies under the Family and Medical Leave Act (FMLA).

Your coverage may also be affected if there is an annual enrollment during Your leave or if You are married to another Southwest Employee. If Your Medical, Dental, Vision, or Health Care FSA coverage ends during Your leave, You and Your covered Family Member may be eligible to continue coverage under COBRA. For additional information on COBRA coverage, see Section 1 of this SPD.

PAYMENT OF PREMIUM DURING YOUR LEAVE OF ABSENCE: While on leave of absence, You are responsible for the payment of any premium due to Southwest during Your Continuation of Coverage Period. If You do not receive a paycheck to cover Your premiums or You do not have enough in your pay check to cover your premiums, then You may be mailed a letter asking for payment and detailing the amount past due.

Submit all payments by check or money order to:
Southwest Airlines Co.
Health & Wellness Team HDQ-6EB
P.O. Box 731180
Dallas, TX 75373-1180

All payments are due on the first day of the Month. A 30-day grace period will apply. Any premiums for coverage not collected prior to or during Your leave of absence will be deducted from your first paycheck and subsequent paychecks until paid in full.

ANNUAL ENROLLMENT: If Your Healthcare Coverage will remain in effect as of January 1 of the next Calendar Year then during Your Leave of Absence You will be eligible for annual enrollment during the annual enrollment period. You will be subject to the same enrollment requirements as active Employees. Including, but not limited to, deadline dates, Family Member documentation, effective date of coverage changes. If Your coverage will terminate on or before December 31 of the current Calendar Year, then You will not be eligible for annual enrollment until You return to work.

COVERAGE CHANGES DURING YOUR LEAVE OF ABSENCE:
You may not make changes (other than those specified in this section of the SPD) to Your benefit coverage during Your leave of absence unless You have a Qualified Life Event For additional information, see section 1 of this SPD.

- **FMLA and Military Leave Exception:** If You do not wish to continue Your coverage while on FMLA or military leave of absence, then You may elect to drop all coverage for You and Your Family Members by submitting a written request to the Health & Wellness Team within 30 days of the first day of Your leave. Your termination of coverage will be effective on the date the Health & Wellness Team receives Your written request.
- **If You drop coverage while on leave of absence, then:** You may not reinstate Your coverage until You return to Active Work; however, You will be given an opportunity to reinstate Your Healthcare Coverage by electing coverage under COBRA when Your FMLA healthcare or military leave of absence Continuation of Coverage Period would have ended had You not elected to drop coverage. Although a Committed Partner is not eligible for COBRA, the Committed Partner may be eligible for continuation coverage (see Partner Policy) and You may add them upon Your return to work, provided the Committed Partner was covered prior to Your leave and is still eligible under the Plan.

LAPSE IN COVERAGE IN REGULAR MEDICAL PLAN PROGRAM: If You have coverage under the Regular Medical Plan Program and that coverage terminates during Your leave of absence, You will be subject to the preexisting conditions provision of the Regular Medical Plan Program upon re-enrollment, unless prohibited by law.

FAMILY AND MEDICAL LEAVE ACT (FMLA): The Plan will comply with the Family and Medical Leave Act of 1993 (FMLA). Your existing Healthcare Coverage will continue for the duration of an approved FMLA leave unless You choose not to retain Your Healthcare Coverage while on FMLA leave. You may be eligible for further extension of coverage beyond Your FMLA leave based on the type of Your Leave of Absence, as described in the Continuation of Coverage Period Chart. Please see Southwest's Employee Rights and Responsibilities Notice Under the FMLA at SWALife>AboutMe for additional information about FMLA leave.

RETURNING TO WORK FROM A LEAVE OF ABSENCE:

- If You return to Active Work before Your Continuation of Coverage Period ends, then You will remain enrolled in the same coverage at the same coverage levels that were in effect as of Your return to work date.

- If You return to Active Work after Your Continuation of Coverage Period ends, and Your benefits were in effect as of January 1 of the Year You return, then You will automatically be re-enrolled in the same coverage at the same coverage levels that were in effect when Your coverage ended.

- If You return to Active Work after Your Continuation of Coverage Period ends and Your benefits were not in effect as of January 1 of the Year You return, then You will automatically be enrolled in the same coverage at the same coverage levels that were in effect prior to the date Your coverage ended. You will be eligible to make new enrollment elections if You do so by the deadline date set by Southwest upon Your return to Active Work and Your elected coverage will be effective on the date You return to Active Work performing Your regular job. Coverage that is subject to Statement of Health will not become effective until the date the insurance carrier approves Your coverage (if the approval date is after Your return to work date).

- **If You did not continue coverage under COBRA while on a leave of absence or COBRA is exhausted,**
  (i) then You may add a Family Member who becomes newly eligible during Your leave of absence due to marriage, birth, or adoption (including placement for adoption) if You notify the Health & Wellness Team within 30 days of Your return to work date; and

  (ii) if You obtained other coverage while on leave of absence, and if coverage under the Plan could have been reinstated upon Your return to work, then You may elect to drop coverage if You notify the Health & Wellness Team within 30 days of Your return to work date.

- **If Your Health Care FSA or Dependent Care FSA terminated during Your leave,** then Your participation in the spending accounts cannot be reinstated or activated until You enroll during Your next available enrollment period.

CONTINUATION OF COVERAGE PERIOD: While You are on a leave of absence, Your leave type will determine Your Continuation of Coverage Period. **If the type of Your leave changes during Your leave of absence (for example, a Medical leave to a Personal Leave), then Your Continuation of Coverage Period will be recalculated based on Your new leave type. This may result in an earlier end of coverage date than was calculated for Your previous leave of absence. The following terms are key to understanding Your Continuation of Coverage Period.**

- **Last Day Actively at Work** is the last day You are physically at work performing Your regular job (for Flight Attendants, this is the last day You actually fly and for Pilots, this is the last day you are eligible to fly) including any immediately succeeding originally scheduled regular non-working day. Shift trades, trip trades, giveaways, etc. are not considered originally scheduled regular non-working days.

- **Continuous Pay Period,** except where state laws are applicable, the period of any eligible accrued sick leave and/or vacation time paid to You for each consecutive originally scheduled work day beginning from the date Your Continuous Pay Period begins as determined by Your leave type. Trip trades, giveaways, shift trades, etc. are not considered as originally scheduled workdays.

No accrued sick leave is eligible for purposes of calculating Continuous Pay Period for leave of absence for Military, Military Exigency, Care of a Military Servicemember, Personal, Family Personal, or Adoption of a Child.

- **Non-Continuous Pay Period** will be calculated using the balance of any eligible accrued sick leave, vacation time, and occupational injury trips which were available to You on Your leave of absence start date and not paid to You during Your Continuous Pay Period. No accrued sick leave is eligible for purposes of calculating Non-Continuous Pay Period for leave of absence for adoption of a child. Occupational injury trips are eligible for purposes of calculating Non-Continuous Pay Period **only** for Pilots and **only** if they are on Military Leave. The Non-Continuous Pay Period begins on the day following the day on which Your Continuous Pay Period ends. The Non-Continuous Pay Period ends when days are exhausted as calculated below.

The Non-Continuous Pay Period for **Employees other than Flight Attendants and Pilots** will be calculated as follows:

1. The hours of pay will be divided by a Monthly factor to determine a Month of pay. The Monthly factor for Fulltime Employees is 173.33 and the Monthly factor for Parttime Employees is 86.67. A fraction of a Month will be converted to a day by multiplying the fraction times 30 to determine additional days of pay.
2. The calculated Months and days of pay will be added to all eligible accrued vacation days and the sum of these days will be Your Continuous Pay Period.

The Non-Continuous Pay Period for **Flight Attendants and Pilots** will be calculated as follows:

1. The balance of all Your eligible accrued sick leave trips and eligible occupational injury trips will be divided by a trip multiplier to calculate Months of pay. The trip multiplier for Flight Attendants is 90 and the trip multiplier for Pilots is 95.
2. Months of pay, including fractions of a Month, will be multiplied by 30 to calculate days of pay for eligible accrued sick leave trips and eligible occupational injury trips.
3. The calculated sick days of pay, eligible accrued vacation days, and eligible occupational injury days will be Your Continuous Pay Period.

▪ **Supplemental Hospital Insurance** coverage will end when Your Medical Program coverage ends based on Your leave type as described in the charts below and will be reinstated upon Your return to Active Work. Any premiums owed will be deducted from Your paycheck upon Your return to Active Work.

▪ **Pet and Auto Insurance** will not be payroll deducted if You are not receiving a paycheck. You will receive a bill in the mail to pay the premiums directly to the Insurance Carrier.

▪ **Health Spending Account (HSA):** If HSP medical option coverage ends as described in the chart below, then Your eligibility to make contributions to the HSA also ends. While on leave of absence, if your HSP medical option coverage continues, then You may continue to participate in the HSA; however, if You do not receive a paycheck, then no deduction can be withheld and no contribution will be made to Your HSA for that pay period. This missed contribution will not be automatically made up on a future paycheck. If you would like to make direct contributions while on leave of absence, then You should contact the HSA bank for assistance with deposit via personal check. Your automatic contributions will resume when You return from leave and start receiving paychecks.

CONTINUATION OF COVERAGE PERIOD CHART

	Medical Leave of Absence	Parental Leave of Absence (Flight Attendants Only)	Adoption of Child Leave of Absence
Period Begins	Your last day Actively at Work	The date Your Parental Leave begins.	Your last day Actively at Work
Medical, Dental, and Vision	**The later of:** ▪ Last Day Actively At Work plus Continuous Pay Period plus Non-Continuous Pay Period plus 120 consecutive calendar days or ▪ The Continuation of Coverage Period under FMLA	You are eligible to continue coverage through the duration of Your parental leave of absence. If any of these coverage ended before Your parental leave began, then You are eligible to have them reinstated for the term of Your parental leave.	**The later of:** ▪ Date Your leave begins plus Number of FMLA hours available to You on the date leave begins or ▪ Date Your leave begins plus Continuous Pay Period plus Non-Continuous Pay Period plus 84 consecutive calendar days (12 weeks)
Health Care FSA and Dependent Care FSA	You are eligible to continue to participate through the same date that Medical Program eligibility would end for You as described above or December 31 of the Year in which Your leave begins, whichever is earlier.	You are eligible to continue to participate through the same date that Medical Program eligibility would end for You as described above or December 31 of the Year in which Your leave begins, whichever is earlier.	You are eligible to continue to participate through the same date that Medical Program eligibility would end for You as described above or December 31 of the Year in which Your leave begins, whichever is earlier.
Life, AD&D, LTD, and Spouse/ Child Life	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days.	Your eligibility will be recalculated as though You had switched from Medical Leave to Personal Leave.	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days

CHART OF CONTINUATION OF COVERAGE PERIOD

	Family Personal Leave of Absence (FMLA)	Personal Leave of Absence	Workers Compensation Leave of Absence (Occupational Injury)
Period Begins	The day Your FMLA begins	Your last day Actively at Work	Your last day Actively at Work
Medical, Dental, and Vision	Date Your FMLA Leave begins plus Number of FMLA hours available to You on the date leave begins.	Last Day Actively At Work plus Continuous Pay Period plus 30 consecutive days	**The later of:** ▪ Last Day Actively At Work plus Occupational Injury Pay (salary continuation) plus Continuous Pay Period plus Non-Continuous Pay Period plus 120 consecutive calendar days or ▪ Continuation of Coverage Period under FMLA
Health Care FSA and Dependent Care FSA	You are eligible to continue to participate through the same date that Medical eligibility would end for You as described above or December 31 of the Year in which Your leave begins, whichever is earlier.	You are eligible to continue to participate through the same date that Medical eligibility would end for You as described above or December 31 of the Year in which Your leave begins, whichever is earlier.	You are eligible to continue to participate through the same date that Medical eligibility would end for You as described above or December 31 of the Year in which Your leave begins, whichever is earlier.
Life, AD&D, LTD, and Spouse/ Child Life	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days

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CHART OF CONTINUATION OF COVERAGE PERIOD

	FMLA Military Exigency	FMLA Military Care of a Servicemember	Military Leave of Absence
Period Begins	The day Your FMLA begins.	The day Your FMLA begins.	Your last day Actively at Work.
Medical, Dental, Vision, and Healthcare Spending Account	Date Your leave begins plus Number of FMLA hours available to You on the date leave begins.	Date Your leave begins plus Number of FMLA hours available to You on the date leave begins. (An Employee may have up to 26 weeks of FMLA leave.)	**The later of:** ▪ Last Day Actively At Work plus Continuous Pay Period plus Non-Continuous Pay Period plus applicable # of consecutive calendar days or ▪ The Continuation of Coverage Period under FMLA **Note:** Applicable # of consecutive calendar days by work group as listed below: Non-Contract Employees, Customer Service Agents, Ramp Agents, Operations Agents, Provisioning Agents, Freight Agents, Customer Representatives, and Flight Crew Training Instructors: **204 days** Flight Attendants, Flight Simulator Technicians, Dispatchers, Mechanics, Stock Clerks and Aircraft Appearance Technicians: **225 days** Pilots: **120 days** **Note:** Accrued sick time and accrued occupational injury trips will be used for the purpose of extending benefit coverage only. In no event does it imply that You are eligible to receive sick pay or occupational injury pay while on a Military Leave of Absence. **Note:** If You take a Qualified Reservist Distribution from the Health Care FSA, then Your participation in the Health Care FSA terminates.
Dependent Care FSA	December 31 of Calendar Year of the Last Day Actively at Work.	December 31 of Calendar Year of the Last Day Actively at Work.	December 31 of Calendar Year of the Last Day Actively at Work.
Life, AD&D, LTD, and Spouse/ Child Life	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days	The Continuation of Coverage Period for Your Healthcare Coverage plus 90 consecutive calendar days.

ADDITIONAL LEAVE OF ABSENCE RULES THAT APPLY IF YOU ARE A SOUTHWEST EMPLOYEE MARRIED TO A SOUTHWEST EMPLOYEE:

- **Medical, Dental, and Vision under the BenefitsPlus Options:** If You are the dependent Spouse, then Your coverage will continue under the primary Spouse. If You are the primary Spouse then Your coverage will remain unaffected until You reach the end of Your Continuation of Coverage Period. When Your Continuation of Coverage Period ends, Your Spouse will become the primary Spouse and Your coverage will continue under Spouse. If the period during which You are receiving pay ends prior to the end of Your Continuation of Coverage Period, then You may request that Your Spouse become the primary Spouse at that time.

- **Medical, Dental, and Vision under the Regular Medical Plan Option:** Your coverage will remain unaffected until You reach the end of Your Continuation of Coverage Period. When Your Continuation of Coverage Period ends, Your Spouse will become the primary Spouse and Your coverage will continue under Spouse.

- **Additional Rules for Vision Only:** If the Spouse who takes a leave of absence is (i) classified as an Aircraft Appearance Technician, Customer Service Agent, Dispatcher, Mechanic, Pilot, Reservation Agent or Stock Clerk, (ii) is enrolled in the Regular Plan medical option, and (iii) has Employee+Spouse, Employee+Children or Employee+Family coverage, and (iv) this coverage ends due to reaching the end of the Continuation of Coverage Period, then the other Spouse **must** continue the coverage and assume payroll deductions for Vision Coverage. If the Spouse who takes a leave of absence is (i) not eligible to continue coverage due to job classification or has Employee Only coverage and (ii) Vision coverage ends due to reaching the end of the Continuation of Coverage Period, then such coverage may be continued under COBRA.

- **Health Care and Dependant Care Spending Accounts:** If the Spouse who takes a leave of absence is contributing to either account and coverage ends due to reaching the end of the Continuation of Coverage Period, then the remaining Spouse must assume responsibility for payroll deductions. Such contributions will continue through the end of the leave of absence or the end of the Calendar Year in which the leave began, whichever occurs first.

- **Life, AD&D, and Long Term Disability:** During Your Continuation of Coverage Period, You are responsible for making Your individual contributions for these coverages. When Your Continuation of Coverage Period ends, Your coverage ends; however, the primary Spouse may enroll You in Spouse Life Insurance within 30 days of Your end of coverage date.

- **Child Life:** If the Spouse who takes a leave of absence is enrolled in Child Life and this coverage ends due to reaching the end of the Continuation of Coverage Period, then the remaining Spouse must assume payroll deductions for continuing this coverage.

END OF SECTION

MEDICAL PROGRAM

GENERAL INFORMATION: The Plan's Medical Program offers You four options and there are significant differences between these options. You must choose between one of the three options under BenefitsPlus (Choice Plus Plan, Choice Plan C, or the Health Savings Plan (HSP)) or the Regular Plan. On the following pages You will find the additional information about each option, a chart that summarizes characteristics, benefits, and requirements for each option, additional information that further explains the information summarized in the chart, and limitations and/or benefits that may apply to one or more options

- **All options require advance notification and/or approval prior to an inpatient hospital stay including emergency admission.**

BENEFITSPLUS OPTIONS:

UNITEDHEALTH PREMIUM PROGRAM: If You choose BenefitsPlus, then You may have access to Physicians or facilities that have been designated as part of the UnitedHealth Premium Program. Based on quality and efficiency of care, the UnitedHealth Premium Program identifies Physicians and facilities that have met the UnitedHealth criteria for premium care. For additional information on the UnitedHealth Premium Program, including how to locate a UnitedHealth Premium Physician or facility, log onto **myuhc.com** or call the toll-free number on Your ID card.

- **Choice Plus Plan:** The Choice Plus Plan offers In-Network benefits and Out-of-Network benefits, although it covers more for In-Network. It includes Copayments for office visits and generic drugs and pays a percentage of the costs for other medical care as well as non-generic drugs.

- **Choice Plan C:** Choice Plan C is a comprehensive medical option offered to You at lower premium cost but with higher Deductibles, higher Out-of-Pocket maximums, and additional limitations in connection with some services. Choice Plan C has In-Network benefits and Out-of-Network benefits, although it covers more for the In-Network benefits. Employees on this plan will pay a Coinsurance for office visits and prescriptions. There is a separate annual Deductible for prescriptions that must be met prior to coverage. Choice Plan C does not cover well newborn care.

- **Health Savings Plan (HSP):** The HSP is a comprehensive medical option that offers lower Monthly contributions compared to the other BenefitsPlus options, but notably higher Deductible and higher Coinsurance requirements compared to the other medical options. **Employees in the HSP are responsible for the full cost of all healthcare expenses (other than qualified preventive care) until the higher Deductible and Coinsurance are satisfied.** The Deductible applies to Covered Health Services under the Medical Program including Prescription Drugs. Employees in the HSP may elect to contribute to a tax-advantaged Health Savings Account (HSA).

REGULAR PLAN OPTION: The Regular Plan medical option is a comprehensive medical option, however, the Regular Plan either does not offer, or offers but limits, many of the benefits that may be available under BenefitsPlus. You should carefully review these limitations and all information in this SPD about the Regular Plan before selecting this option.

- **Under the Regular Plan medical option, You are required to pay the charges at the time of service and file a claim for reimbursement of Covered Charges, unless the Provider agrees to file a claim for reimbursement on Your behalf. The Regular Plan medical option includes preexisting condition limitations and is a grandfathered plan under the health care reform regulations.**

- If you would like to enroll in the Regular Plan, you must contact the Health & Wellness Team before using the online enrollment tool so that you can be registered. You will be required to complete a Benefits Request for Program Change Form. You must allow 24 hours to process your Benefits Request for Program Change Form before you enroll using the online enrollment tool. If you switch from the BenefitsPlus program to the Regular Plan, then You and Your family members over the age of 19 may be subject to a three-Month preexisting condition limitation.

- You may not enroll a Committed Partner in the Regular Plan.

MEDICAL PROGRAM OPTIONS COMPARISON CHART

	Choice Plus Plan [5]	Choice Plan C [5]	Health Savings Plan (HSP) [6]	Regular Plan (Grandfathered Plan)
Annual Deductible	In-Network: $300/Per Person; $750/Family Out-of-Network: $600/Per Person; $1,500/Family (does not apply to Out-of-Pocket Maximum)	In-Network: $800/Per Person; $2,000/Family Out-of-Network: $1,500/Per Person; $3,750/Family (does not apply to Out-of-Pocket Maximum)	In-Network/Out-of-Network: $1,500/Employee Only; $3,000/Family(6) (does not apply to Out-of-Pocket Maximum)	$200/Per Person; $300/Family
Copayment/Services Performed by Physician (Copayment does not apply towards Deductible or Out-of-Pocket Maximum)	In-Network coverage is 100% after appropriate copayment for office/facility visits: convenience care clinic $15[2]; Physician office visit $25; specialist office visit $40; urgent care $40; emergency room $150 Other services are covered after annual deductible is met. In-Network Coverage 85% and Out-of-Network Coverage 60%.	Copayment not available	Copayment not available	Copayment not available
General Level of Benefit Coverage (inpatient and outpatient)	In-Network Provider: 85%; Out-of-Network Provider: 60% (after annual Deductible)	In-Network Provider: 80% Out-of-Network Provider: 60% (after annual Deductible)	In-Network Provider: 80% Out-of-Network Provider: 60% (after annual Deductible)	80% after annual Deductible (office visits, inpatient, outpatient)
Preventive Care for (no Deductible) Adult and Children	In-Network Provider: 100% Out-of-Network Provider: 100% of Reasonable and Customary	In-Network Provider: 100% Out-of-Network Provider: 100% of Reasonable and Customary	In-Network Provider: 100% Out-of-Network Provider: 100% of Reasonable and Customary	Not Covered (well visits, physicals, etc)
Newborn Care (inpatient) Includes: circumcision, room and board, general nursing care, and Doctor's fees.	In-Network Provider: 85%; Out-of-Network Provider: 60% (after annual Deductible)	No Coverage	In-Network Provider: 80% Out-of-Network Provider: 60% (after annual Deductible)	Not Covered
Prescriptions	See prescription chart for details	See prescription chart for details	See prescription chart for details[4]	See prescription chart for details
Infertility Treatment (Pre-authorization required by UHC)	SERVICES[1]: 50% Coinsurance after $500 separate lifetime Deductible (infertility treatment only); Employee and souse combined; $10,000 lifetime maximum – You and your Spouse/Committed Partner combined. PRESCRIPTION DRUGS: In-Network Provider: 50% Coinsurance; $5,000 lifetime maximum for You and Your Spouse/Committed Partner combined Out-of-Network Provider: No Coverage	No Coverage	No Coverage	No Coverage
Applied Behavioral Analysis (ABA) Therapy	No Coverage	No Coverage	In-Network Provider: 80% Out-of-Network Provider: 60% (after annual Deductible)	No Coverage

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MEDICAL PROGRAM OPTIONS COMPARISON CHART

	Choice Plus Plan [5]	Choice Plan C [5]	Health Savings Plan (HSP) [6]	Regular Plan (Grandfathered Plan)
Employee Assistance Program (EAP): ClearSkies	In-Network Provider: Up to five appointments per person, per issue, per Year, with ClearSkies at no charge. Out-of-Network: No Coverage	In-Network Provider: Up to five appointments per person, per issue, per Year, with ClearSkies at no charge. Out-of-Network: No Coverage	In-Network Provider: Up to five appointments per person, per issue, per Year, with ClearSkies at no charge. Out-of-Network: No Coverage	In-Network Provider: Up to five appointments per person, per issue, per Year, with ClearSkies at no charge. Out-of-Network: No Coverage
Mental, Emotional, Behavioral and Chemical Abuse/Dependency Benefits Preauthorization[3] Prescription Drugs are covered under the Prescription Drug Program	In-Network Provider: Inpatient 85% Outpatient 85% with $25 Copayment	In-Network Provider: Outpatient/Inpatient 80% Out-of-Network Provider: Outpatient/Inpatient 60% (after annual Deductible)	In-Network Provider: Outpatient/Inpatient 80% Out-of-Network Provider: Outpatient/Inpatient 60% (after annual Deductible)	Outpatient: 80% Inpatient: 80%
Annual Out-of-Pocket Maximum[7]	In-Network: $3,200/Per Person; $6,400/Family Out-of-Network: $6,400/Per Person; $12,800/Family	In-Network: $4,000/Per Person; $8,000/Family Out-of-Network: $6,000/Per Person; $12,000/Family	In-Network: $4,500/Per Person; $9,000/Family Out-of-Network: $6,750/Per Person; $13,000/Family	$2,500
Lifetime Maximum (combined Medical and Mental Health and Chemical Dependency	No Limit	No Limit	No Limit	No Limit

(1) Charges for all prescription drugs and infertility treatment will not apply to the Choice Plus Plan annual Out-of-Pocket Maximum or annual medical Deductible. Certain Provider and coverage limitation apply to infertility treatment. You must contact UnitedHealthcare prior to receiving infertility treatment and request the infertility questionnaire.
(2) List of Convenience Care Clinics available at www.myuhc.com
(3) Refer to the SPD on SWALife>About Me> for preauthorization rules for each medical plan
(4) List of Specified Preventive medications may be found at SWALife>About Me>My Benefits
(5) For the Choice Plus Plan and Choice Plan C, when an individual in a family meets the individual Deductible, Coinsurance applies. When the Family Deductible amount is met, the rest of the family will receive Benefits. One participant can never incur Deductible expenses above the individual limit. Family Deductible may be reached by two or more Family Members, even if each Family Member does not satisfy the individual Deductible amount.
(6) For the HSP, if you have anything other than Employee Only coverage, then you will be subject to the entire Family Deductible before any Family Member receives a benefit.
(7) For additional information on Your Out-of-Pocket Maximum, including what does not count toward your Out-of-Pocket Maximum, refer to the paragraph in the Medical Program section that specifically discusses Out-of-Pocket Maximum.

PREVENTIVE CARE (PHYSICAL EXAMS): The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider, Hospital or Physician.

- If you are enrolled in a BenefitsPlus medical option, all preventive treatment is covered at 100%.
- FAA physicals required for pilots to maintain their medical certificate are not preventive care and are not a covered Benefit.

General Level of Benefit Coverage: After each Covered Individual pays required Copayments and Deductibles, then the Medical Program pays for Covered Charges at the levels shown in the summary chart on the preceding pages. For the Choice Plus Plan, the eligible amount of reimbursement for Out-of-Network Providers is based on Allowable Amount charges.

Annual Deductible: The Deductible is the amount of Covered Charges You pay each Calendar Year before the Medical Program begins reimbursing You for Covered Charges. Your Deductible starts over each January 1.

- Except as listed below or otherwise in this SPD, all Covered Charges count toward the Annual Deductible.

Medical Program Option	Amounts That Do Not Count Toward the Annual Deductible
BenefitsPlus—Choice Plus Plan	•Copayments •Coinsurance •Prescription drugs (including Your prescription Coinsurance and Copayments) •Infertility treatment
BenefitsPlus—Choice Plan C	•Coinsurance •Prescription drugs (including Your prescription Coinsurance)
BenefitsPlus—HSP	•Coinsurance
Regular Plan	•Coinsurance

- Once Your Deductible is satisfied, if You use an In-Network Provider, then You only pay Your portion after the Medical Program benefits are paid. Once Your Deductible is satisfied, if You use an Out-of-Network Provider or are enrolled in the Regular Plan medical option, then You may be required to pay the full amount at time of service and use a Claim Form to request reimbursement for the Plan's portion.

- Under the BenefitsPlus HSP medical option, **unlike the other BenefitsPlus options, there is no Deductible for individual** Family members. There is only one Deductible for the entire Family that is significantly higher than the other BenefitsPlus options. With "Employee Only" coverage in the HSP, the Employee will be subject to the "Employee Only" Deductible of $1,500. With any other coverage level besides "Employee Only" (including any Committed Partner coverage), the "Family" Deductible of $3,000 must be met.

- Under the **Regular Plan medical option**, Covered Charges incurred during October, November and December and applied to the Deductible will also be applied to the Deductible for the next Calendar Year.

Out-of-Pocket Maximum:
The annual Out-of-Pocket Maximum is the most You pay each Calendar Year for Covered Health Services. There are separate In-Network and Out-of-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a Calendar Year exceed the annual maximum, the Plan pays 100% of Eligible Expenses through the end of the Calendar Year.

The following table identifies what does and does not apply toward Your In-Network and Out-of-Network Out-of-Pocket Maximums.

Plan Features	Applies to the In-Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Copayments	No	No
Payments toward the Annual Deductible	No	No
Coinsurance Payments	Yes	Yes
Charges for non-covered health services	No	No
The amounts of any reductions in Benefits You incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

IN-NETWORK PROVIDER: In general, if You select an In-Network Provider You will receive negotiated rates that are discounted from standard rates and the portion of charges that You will be responsible for will be less than if You choose an Out-of-Network Provider.

MEDICAL PROGRAM OPTION	IN-NETWORK PROVIDER REQUIREMENT
BENEFITSPLUS—CHOICE PLUS PLAN	OPTIONAL
BENEFITSPLUS—CHOICE PLAN C	OPTIONAL
BENEFITSPLUS—HSA	OPTIONAL
REGULAR PLAN MEDICAL OPTION	NO

- If You enroll in a BENEFITSPLUS medical option, You may choose to use In-Network Providers that have agreed to provide treatment at negotiated rates.
- If You enroll in the REGULAR PLAN medical option, an In-Network Provider program for negotiated rates is not available to You.

▪ In-Network Providers are independent practitioners and are not Employees of Southwest or the Claims Administrator. It is Your responsibility to select Your In-Network Provider. The Claims Administrator's credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided.

▪ You will be given access to a directory of In-Network Providers via the Claims Administrator's website. You may request a paper directory from the Claims Administrator at no cost to You. A Provider's status may change at any time. Before obtaining services You should always verify the In-Network status of a Hospital, Physician, other Provider or facility by calling the Claims Administrator. It is Your responsibility to make sure that the Hospital, Physician, or other Provider is qualifies as an In-Network Provider for the date of service.

▪ You must select an alternate In-Network Provider if a Provider (i) cannot perform the services that You need, (ii) is not accepting new patients, or (iii) no longer maintains status as an In-Network Provider.

▪ Do not assume that an In-Network Provider agreement includes all Covered Charges. Some In-Network Providers agree to provide only certain services under an In-Network Provider agreement and, therefore, some services or products performed by or from an In-Network Provider may actually be treated as if performed by or from an Out-of-Network Provider. To determine if a certain service or product by any Provider qualifies as covered by an In-Network Provider, refer to the Claims Administrator's website or contact the Claims Administrator.

▪ **Steps to Use an In-Network Provider**

1. Choose a Doctor, Hospital or other Provider from the applicable In-Network directory.
2. Confirm the selected Doctor, Hospital or other Provider will be a qualified In-Network Provider on Your date of service.
3. Present Your I.D. card to the Provider.
4. Follow any required procedures prior to admission for notification to the Claims Administrator of Hospital stays and surgery. You are responsible for making sure these procedures are followed. If the procedures are not followed, Your Benefits may be reduced.
5. Request an itemized bill.
6. Confirm with Your In-Network Provider and the Claims Administrator that You do not need to file a Claim Form.

▪ **BenefitsPlus Network Gap Exception:** You may qualify to receive a Network Gap Exception that may be approved when there are no In-Network Providers available in the required specialty, within a 30 mile radius of the Your home zip code. This Network Gap Exception would allow You to receive In-Network benefits for services provided by an Out-of-Network Provider. To request authorization for a Network Gap Exception call Personal Health Support before services are provided. If services are provided prior to a Gap Exception approval, then the services will be paid as Out-of-Network.

PREAUTHORIZATION REQUIREMENTS: Many services, treatments, and hospital stays require preauthorization from the Claims Administrator. This process helps You and Your Family Members avoid unnecessary treatment, hospital stays, and charges. To obtain preauthorization You must contact:

UnitedHealthCare
Personal Health Support
877-246-0857

- **You will only receive full benefits if UHC provides the required preauthorization. No benefits are available without advance determination that the procedure is a Covered Health Service.** Whether Benefits are payable are always based on (i) the services and supplies actually performed or given and (ii) the Covered Individual's eligibility under the Plan on the date the Covered services and supplies are performed or given.

- The Claims Administrator determines whether services and/or hospitalization is necessary and assigns an appropriate length of time for hospital stays; however, the Claims Administrator is not a substitute for the medical judgment of the Covered Individual's Physician. The ultimate decision as to what medical care a Covered Individual actually receives must be made by the Covered Individual and the Physician.

- **Treatments that do not have required approval from Personal Health Support are subject to an additional $500 Deductible.**

REQUIREMENTS FOR NOTIFYING PERSONAL HEALTH SUPPORT:

Regular Plan: If you are enrolled in the Regular Plan, You **responsible for notifying Personal Health Support prior to receiving any services.**

Benefits Plus: If you are In-Network providers are generally responsible for notifying Personal Health Support before they provide certain services to You. However, there are some In-Network Benefits for which You are responsible for notifying Personal Health Support. When You choose to receive certain Covered Health Services from an Out-of-Network Provider, You are responsible for notifying Personal Health Support before You receive these Covered Health Services. In many cases, Your Out-of-Network Benefits will be reduced if Personal Health Support is not notified. The services that require Personal Health Support notification are:

- ambulance – non-emergent air and ground;
- Congenital Heart Disease services;
- dental services—accident only (penalty does not apply);
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes (penalty does not apply);
- home health care (penalty does not apply);
- hospice care—inpatient;
- Hospital Inpatient Stay, including Emergency admission;
- infertility services;
- maternity care that exceeds the delivery timeframes for an inpatient stay for a mother and/or the newborn that will be more than the time frames described: 48 hours for the mother and newborn child following a vaginal delivery; or 96 hours for the mother and newborn child following a cesarean section delivery.
- mental health services—inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45—50 minutes in duration, with or without medication management;
- neurobiological disorders—mental Health Services for Autism Spectrum Disorders -inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45—50 minutes in duration, with or without medication management; Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- reconstructive procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery (Penalty does not apply);
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services—inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45—50 minutes in duration, with or without medication management; and
- transplantation services.

REGULAR PLAN –PREEXISTING CONDITION LIMITATION: **The Regular Plan medical option includes preexisting condition limitations.** Subject to the Creditable Coverage provision, the preexisting condition provision of the Regular Plan medical option will apply (i) if a Covered Individual changes from a Southwest Medical Program or plan to the Regular Plan and (ii) on the date coverage under the Regular Plan medical option is reinstated if a Covered Individual's coverage is terminated under any Southwest medical program or plan. If You have any questions regarding whether the preexisting conditions limitation period applies to You, call the Claims Administrator.

A preexisting condition for purposes of the Regular Plan medical option is a medical condition or a mental, emotional, behavioral or chemical abuse/dependency condition if it is a physical or mental condition (regardless of cause) for which a Covered Individual (You or one of Your Covered Family Members) received (or had recommended) medical advice, diagnosis, care, or treatment within three Months before (i) Your date of hire if You are a newly hired Employee and the Covered Individual's coverage becomes effective immediately after You satisfy the eligibility period, or (ii) in all other cases, the Covered Individual's effective date of coverage under the Regular Plan medical option. Preexisting condition limitations do not apply to pregnancy or to those plan members under the age of 19.

•If a Covered Individual has a preexisting condition, his or her coverage under the Regular Plan medical option for the same condition will be limited to $500 (after any applicable Deductibles, Coinsurance, and other contributions) for 12 Months after *the later of (i)* Your date of hire if You are a newly hired Employee and the Covered Individual's coverage becomes effective immediately after You satisfy the eligibility period *or (ii)* the Covered Individual's effective date of coverage in all other cases. The 12 Month preexisting conditions limitation period described above is reduced by one day for each day of Creditable Coverage of the Covered Individual who has the preexisting condition.

•This preexisting condition limitation on benefits will cease to apply to a Covered Individual with a preexisting condition if he or she goes three consecutive Months without medical advice, diagnosis, care, or treatment for that same condition. Your eligible newborn child or Your eligible unmarried child under age 19 who is legally adopted by or placed for adoption with You will not be subject to the limitation on benefits described above if the child is enrolled for benefits in the Regular Plan medical option within 30 days after birth, adoption, or placement for adoption or if the child has Creditable Coverage within 30 days after such an event and is enrolled for benefits in the Regular Plan medical option before incurring a Significant Break in Coverage.

•Generally, You and Your Covered Family Members will have received a "Certificate of Creditable Coverage" from Your or their prior healthcare plan or insurer as proof of prior coverage. You should retain those Certificates until You submit a claim. When a claim for treatment of a potential preexisting condition is received, the Claims Administrator will request a Certificate of Creditable Coverage and will determine at that time if the Covered Individual with the potential preexisting condition has Creditable Coverage.

•If the Claims Administrator requests a Certificate of Creditable Coverage from a Covered Individual, and the Covered Individual did not receive one from a prior health plan or insurer, the Covered Individual may request a copy from each prior health plan or insurer with whom the Covered Individual had medical coverage within the past two Years. The Claims Administrator can assist the Covered Individual with such a request and can provide the Covered Individual with the type of information that he or she will need to request from each prior health plan or insurer.

PRESCRIPTION COVERAGE IN GENERAL: **Your prescription coverage will depend on the medical option that you select as described below. Some common terms that refer to various types of medication are listed immediately below.**

▪ **Generic Prescriptions**—A generic is a copy of a name brand drug that is the same in dosage, safety & strength, how it is taken, quality, performance and intended use. The United States Food and Drug Administration require that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same benefits as their name brand counterparts. In the United States close to 50 percent of generic drugs are also made by the name brand company. Generic drugs look different than their name brand counterparts. In the United States trademark laws do not allow a generic drug to look exactly like the name brand drug. The only things that can be different on generic medications are colors, flavors, and other inactive ingredients.

▪ **Preferred Brand Prescriptions**—Medications in this category have been selected as preferred brand name drugs. These drugs cost more than generics but are less costly than non-preferred medications.

▪ **Non-Preferred Brand Prescriptions**—Because a generic version or a preferred name brand alternative is available these drugs are classified as non-preferred. These drugs usually cost more than the preferred medications.

▪ **Compound Medications**–Compound medications are handmade ointments, powders, creams, liquids, gels, sprays, etc. Compound medications are generally made at compounding pharmacies and some limited compounding services can be found at other main stream pharmacies. Depending on the ingredients (drugs) in the medication it can be any one (or combination) of generics, preferred brand or non-preferred brand. It is important to remember that you must use an In-Network pharmacy in order for the drug to be covered.

▪ **Specialty Drugs**—Specialty drugs are used to treat chronic/complex health conditions. Specialty medications generally focus on injectables, infusions and some oral drugs. Specialty medications are therapies that involve strict compliance requirements, special storage, special handling, education, monitoring, and ongoing support. These medications are often used for very costly conditions such as cancer, hepatitis C, multiple sclerosis, psoriasis and rheumatoid arthritis. It is important to contact the Specialty Drug Pharmacy that your prescription drug program uses.

▪ **Diabetic Testing Supplies**—Diabetic testing supplies include items such as, glucose monitoring devices, insulin syringes with needles, pen needles, blood and urine test strips, ketone tablets, ketone test strips and lancet and lancet devices. You may fill your prescriptions at an In-Network Pharmacy or through Mail Service.

PRESCRIPTION MANAGEMENT PROGRAMS:

▪ **Prescription Drug List (PDL)**— All Prescription Drugs covered by the Plan are categorized into tiers on the Prescription Drug List (PDL) by the Claims Administrator. The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. In general the tiers are described as generics and preferred name brands and some plans have additional tiers called non-preferred name brands and specialty drugs. Since the PDL may change periodically, You can visit SWAlife.com, the Claim Administrator's web site or call the Claims Administrator at the toll-free number on Your ID card for the most current information.

Each tier is assigned a Coinsurance/Copayment amount, which is the amount You pay when You visit the pharmacy or order Your medications through mail order.

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety and efficacy, and whether supply limits or notification requirements should apply. Economic factors may include the acquisition cost of the Prescription Drug and available rebates and assessments on the Cost Effectiveness of the Prescription Drug.

Some Prescription Drugs are most Cost Effective for specific indications compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed. When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician. The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to You.

▪ **Mandatory Generic Substitutions**— If You or Your Physician requests a brand name in lieu of an approved generic, You may be subject to mandatory generic substitution and You will typically be required to pay the difference in cost between the brand and the generic drug. Your Physician can request coverage through the Clinical Prior Authorization process if he or she determines there is a documented medical need for the brand-drug equivalent. Select drug products are excluded from the generic substitution due to unique dosage form, complex pharmacokinetics and pharmacodynamics (what the body does to the drug and likewise, what the drug does to the body), narrow therapeutic efficacy and /or where the critical maintenance of the drug blood level is crucial to its efficacy and prevention of adverse effects. The mandated generic substitution process is not intended to supersede any federal, state or local statutes or regulations of the dispensing or generic substitution of any prescription agent.

If a brand-name Prescription Drug becomes available as a Prescription Drug, the tier placement of the Brand-name Drug may change. As a result, Your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug is assigned at the time the Prescription Drug is provided to You.

Managed Care— Prescription drugs are reviewed and approved by the FDA for safety and are to be used for specific medical conditions. Due to the cost of certain drugs and the use of drugs for non-FDA approved conditions (also known as off-label use), You may be subject to prescribing guidelines for certain drugs or classes of drugs. Some managed care guidelines include:

- **Clinical Prior Authorizations** – Requires specific information and request by your physician.
- **Quantity Limitations** – Coverage may be limited to specific quantities per prescription and /or time period.
- **Step Therapy** – Coverage of certain drug may be dependent on previous use or trial of another drug.
- **Age Edit** – Certain drugs may be limited to certain age groups.
- **Gender Edit** – Certain drugs may be limited to a specific gender.

Some categories that generally fall into managed care include, but not limited to, pain management, hormone replacement therapy, erectile dysfunction, attention deficit hypersensitivity disorder, proton pump inhibitors, and fertility.

Managed care requires a Clinical Prior Authorization (CPA) before the Prescription Drug Program will pay for these drugs. To initiate a Clinical Prior Authorization you or your doctor may call the Claims Administrator to start the process. Your doctor will be requested to provide information to meet the clinical criteria.

Maintenance Medications—You may be subject to a mandatory **90-Day Supply Requirement for maintenance medications** (drugs for long-term or chronic conditions), You may have the original 30 day supply of the medication plus two refills filled at a retail pharmacy. For Your third and subsequent refills, You must purchase a 90 day supply of the medication. Your doctor will need to write the prescriptions as a 90 day supply prescription. 90-Day Supply medications can be filled at most In-Network pharmacies or through the Mail Service Program. **You may purchase Your 90 day supply at a local participating retail pharmacy.** A majority of the major network pharmacies participate in the 90 day supply program. **You may be eligible to purchase Your 90 day supply medication from the mail service pharmacy.** Purchasing Your 90 day supply through the mail service option generally saves You and Southwest money. You can find information about mail service by going to the Claims Administrator website or by calling the Claims Administrator at the number on Your card.

COVERAGE INFORMATION:

Prescription Drug Cards— If You are enrolled in the ChoicePlus Plan or Medical Plan C You will receive **prescription drug card(s)** at Your address on record within seven to ten days from the date Your benefits begin. For the Health Savings Plan and the Regular Plan your medical card is also your prescription drug card. You will use Your prescription drug card when You go to the pharmacy.

In-Network Pharmacies— For retail pharmacy purchases, You may only fill Your prescriptions at an In-Network pharmacy. There is no coverage if You go to a pharmacy that is Out-of-Network. If a Covered Individual lives in an area where an In-Network pharmacy is not available, You may be reimbursed after Your Copayment for the amount the Plan would have paid had You used a Network Pharmacy. You will be required to pay the full cost of the prescription at the time of purchase and then submit a claim to the Claims Administrator for reimbursement. You may get a claim form from the Claims Administrator. The HSP medical option provides an option for using Out-of-Network pharmacies. Additionally, You may file manual reimbursement claims for emergency prescriptions while traveling in foreign countries.

Coordination of Benefits— The Coordination of Benefits provision described in this SPD does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Common Drug Exclusions – Certain items are not covered by the Southwest prescription drug program. Exclusions may include, but are not limited to Over-the-Counter (OTC) medications or their equivalents, drug products used for cosmetic purposes, vitamins and minerals (does not include prenatal vitamins), experimental drug products, or any drug used in an experimental manner, foreign drugs or drugs not approved by the United States Food and Drug Administration (FDA), and replacement of lost or stolen medication.

PRESCRIPTION DRUG PROGRAM LIST OF GENERALLY COVERED AND NOT COVERED DRUGS	
COVERED	**NOT COVERED**
•Legend drugs including oral contraceptives •Insulin and diabetic testing supplies •Disposable needles and syringes •Infertility medications (if You are enrolled in ChoicePlus Plan only) •Compound medications if at least one ingredient is a legend drug •Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber •Smoking cessation drugs prescribed by a Physician •Prenatal vitamins prescribed by a Physician	•Anti-obesity agents •Anti-wrinkle agents •Colostomy supplies •Dietary supplements (e.g. nutrients, minerals) •Drugs purchased during time of no coverage •Drugs related to a Workers' Compensation claim •Fluoride supplements •Hair growth stimulants (e.g., Minoxidil) •Hematinics •Immunization agents, blood or blood plasma •Legend medications which have OTC equivalents •Medical supplies or first-aid items •Minerals •Pigmenting/Depigmenting agents •Vitamins, singly or combination •Therapeutic devices or appliances, support garments or other nonmedical appliances, except those listed as covered drugs •Drugs used for Cosmetic Purposes •Charges for the administration or injection of any drug labeled "Caution-limited by federal law to investigational use" •Experimental, Investigational, or Unproven drugs, even though a charge is made to the individual •Any drug for any treatments or conditions which are listed under Charges Not Covered •Non-legend drugs other than those listed as Covered Drugs •Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals

CHOICE PLUS PLAN:

- 90-Day Supply Requirement for maintenance medications.
- Infertility medications covered under the Choice Plus Plan only.
- The BenefitsPlus Choice Plus Plan medical option pays 100% of the cost of the eligible Prescription Drug after You pay a Coinsurance/copayment The following chart shows the applicable Coinsurance/copayment.

PRESCRIPTION DRUG COVERAGE	BENEFITSPLUS—CHOICE PLUS PLAN	
	30 Day Supply Retail	90 Day Supply Retail or Service
Annual Deductible	No Deductible	
Generic	$10	$25
Preferred Brand	25% ($25 min/$50 max)	20% ($45 min/$125 max)
Non-Preferred Brand	45% ($40 min/$150 max)	45% ($60 min/$375 max)
Specialty Drug	25% ($20 min/$150 max)	90 day supply not available
Diabetic Testing Supplies	$0 (Plan pays 100%)	$0 (Plan pays 100%)
Infertility Medications	50% ($5,000 lifetime max benefit coverage)	

CHOICE PLAN C:

- The BenefitsPlus Choice Plan C Drug Program pays 100% of the cost of the eligible prescription drug after You have met Your annual Deductible and paid your Your Coinsurance. The following chart shows the applicable Coinsurance.

PRESCRIPTION DRUG COVERAGE	BENEFITSPLUS—CHOICE PLAN C	
	30 Day Supply Retail	90 Day Supply Retail or Service
Annual Deductible	$50	
Generic	10% ($10 min/$35 max)	7% ($25 min/$88 max)
Preferred Brand	25% ($25 min/$100 max)	20% ($63 min/$250 max)
Non-Preferred Brand	45% ($40 min/$150 max)	45% ($125 min/$375 max)
Specialty Drug	25% ($20 min/$150 max)	90 day supply not available
Diabetic Testing Supplies	$0 (Plan pays 100%)	$0 (Plan pays 100%)

HEALTH SAVINGS PLAN (HSP):

- You have the freedom to go to an Out-of-Network pharmacy by paying 100% of the prescription drug cost at the pharmacy and then filing a paper claim form for reimbursement. Out-of-Network claims are calculated as a percentage of the Predominant Reimbursement Rate.
- 90-Day Supply is available for most medications, but not required.
- A Core list of preventive medications is available without having to meet your annual Deductible. You may determine whether a drug is a Preventive Care Medication by reviewing the list posted on the Claims Administrator's web site or by calling the Claims Administrator.
- The BenefitsPlus HSP medical option pays 100% of the cost of the eligible prescription drug after You have met Your annual Deductible and paid Your Coinsurance. The following chart shows the applicable Coinsurance.

Prescription Drug Coverage	BenefitsPlus—Health Savings Plan	
	30 Day Supply Retail	90 Day Supply Retail or Service
Annual Deductible	$1500/$3000 (combined with health plan Deductible)	
Generic	20%	20%
Name Brand	20%	20%
Specialty Drug	20%	90 day supply not available
Preventative Medications	20% (Deductible waived for core list of preventive medications)	20% (Deductible waived for core list of preventive medications)
Diabetic Testing Supplies	20%	90 day supply not available

REGULAR PLAN:

- 90-Day Supply Requirement for maintenance medications.
- There is no Mail Service Program.
- The Regular Plan medical option pays 100% of the cost of the eligible prescription drug after You pay Your Coinsurance. The following chart shows the applicable Coinsurance.

Prescription Drug Coverage	Regular Plan	
	30 Day Supply Retail	90 Day Supply Retail (no mail service)
Annual Deductible	$200/$300 (combined with health plan Deductible)	
Generic	Covered at 100%	Covered at 100%
Preferred Brand	20%	20%
Non-Preferred Brand	20%	20%
Specialty Drug	20%	20%
Diabetic Testing Supplies	20%	20%

MATERNITY CARE: Pregnancy is treated the same as an illness under the Medical Program and Benefits will be paid at the same level as Benefits for any other Sickness/Illness/Injury including all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications of pregnancy including any disorder or condition which is diagnosed or distinct from normal pregnancy but adversely affected by or caused by pregnancy.

- **Preauthorization may apply to maternity care.** The Preauthorization requirements (including any reductions in Benefits for non-notification) will not apply to any Hospital length of stay in connection with childbirth for the mother or newborn child which is less than 48 hours following a normal vaginal delivery or less than 96 hours following cesarean section. Preauthorization of Hospital length of stay which exceeds these time periods is required. These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other Provider is not required to get authorization for the 48/96 hour time periods described above. Preauthorization is required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes. **Benefits for Hospital stays in excess of the 48/96 hour time periods described above will be subject to Medical Necessity and any reductions in Benefits for non-notification.**

- **For the Regular Plan, only You or Your Spouse who is a Family Member is eligible for maternity care Benefits. Your children are not eligible for maternity care Benefits, including any charges relating to or as a result of complications of pregnancy, even if they are a covered Family Member.**

BENEFITSPLUS—CHOICE PLUS PLAN INFERTILITY TREATMENT: Infertility treatment is ONLY available in the BENEFITSPLUS—CHOICE PLUS PLAN option and only if provided by a Board Certified Reproductive Endocrinologist. For the purposes of this Benefit, infertility is defined as the inability to conceive or carry a pregnancy following at least 12 Months of unprotected intercourse. Covered Individuals with recurrent miscarriages are not deemed to suffer from infertility as defined by this Benefit. Only You and Your Spouse or Committed Partner are eligible for infertility treatment Benefits. Your other Covered Family Members (including children) are not eligible for infertility treatment Benefits.

- **Advance notification requirements apply to infertility treatment.** You must call the Claims Administrator at the phone number on Your BENEFITSPLUS—CHOICE PLUS PPO I.D. card to receive prior-authorization for infertility treatment Benefits. You may choose Your Board Certified Reproductive Endocrinologist.You will need to provide the name and address of Your Board Certified Reproductive Endocrinologist. You and Your Physician will be sent questionnaires to complete and return to the Claims Administrator. Along with the questionnaire, You and Your Physician will receive a current list of infertility services and procedures commonly recognized as Medically Necessary infertility treatment.

- Specific benefit limits, additional Deductibles, and lifetime maximum benefit limits apply to infertility treatment as described below. Charges for infertility treatment will not apply to Your Annual Out-of-Pocket Maximum. Covered infertility services include (i) office visits, (ii) surgical procedures, (iii) other procedures, (iv) in vitro fertilization, (v) laboratory services, and (vi) services related to donor gametes (any fee paid for procurement of donor gametes is excluded). Coinsurance for infertility drugs, non-preferred drugs, and charges for non-covered drugs do not apply toward the Prescription Drug Annual Out-of-Pocket Maximum and also will not be eligible for 100% coverage.

INFERTILITY TREATMENT BENEFITS	RETAIL PRESCRIPTION DRUGS	ALL OTHER COVERED CHARGES
Separate Lifetime Deductible (You and Your Spouse/Committed Partner combined)	None	$500
BENEFITSPLUS—CHOICE PLUS PLAN	In-Network Provider: 50% Out-of-Network Provider: No Coverage	50%
Separate Lifetime Maximum Benefit (You and You Spouse/Committed Partner combined)	$5,000	$10,000

- **Prescription drug Benefits for infertility treatment** must be (i) prescribed by a Board Certified Reproductive Endocrinologist, (ii) approved by the FDA for use in the treatment of infertility, and (iii) purchased at a prescription drug In-Network pharmacy. You must show the In-Network pharmacy Your Prescription Drug I.D. card. You will be required to pay the pharmacy 50% of the cost of the prescription. Prescription drugs for infertility treatment which are not purchased at a participating prescription drug network pharmacy are not to be covered.

- In vitro fertilization (IVF) procedures must be performed at facilities that conform to the minimum standards as established by the American Society of Reproductive Medicine and the Society for Assisted Reproductive Technologies (SART). All such facilities must be JCAHO or CLIA certified, must be members of SART, and must also conform to published SART guidelines regarding the maximum number of embryos transferred as a part of the IVF or frozen embryo transfer procedure.

- Infertility Treatment Benefits are not payable for (i) reversal of either male or female sterilization, (ii) any Experimental, Investigational or Unproven Services, supplies, tests, or treatments, and any related charges, (iii) any charges incurred by You and/or Your Spouse/Committed Partner if any of them are sterilized, (iv) prescription drugs except those fertility drugs that are prescribed by a Board Certified Reproductive Endocrinologist and which are approved by the FDA for use in the treatment of infertility and which are purchased at a participating prescription drug Network Pharmacy, and (v) complications arising from infertility treatment, such as ectopic pregnancy and spontaneous pregnancy loss requiring a D&C. Benefits for complications arising from infertility are provided under the other Medical Program provisions. The above is not an all-inclusive listing of charges not covered.

SUMMARY OF MENTAL HEALTH BENEFITS IN THE MEDICAL PROGRAM: Under the Medical Program there are two resources for Mental Health treatment and counseling: (i) a free Employee Assistance Program (EAP) called ClearSkies and (ii) traditional mental health benefits at levels allowed by Your Medical Program option.

	BENEFITSPLUS MEDICAL OPTION	REGULAR PLAN MEDICAL OPTION	NO MEDICAL COVERAGE OPTION
CLEARSKIES EMPLOYEE ASSISTANCE PROGRAM AVAILABLE	Yes	Yes	Yes
PRECERTIFIED THROUGH THE MENTAL HEALTH CHEMICAL DEPENDENCY PROGRAM (MENTAL, EMOTIONAL, BEHAVIORAL, CHEMICAL ABUSE/DEPENDENCY CONDITIONS) LEVEL OF BENEFIT COVERAGE	**In-Network**[1] 80% Inpatient 80% Outpatient with $25 Copayment **Out-of-Network** 60% Outpatient/ Inpatient[1]	In-Network/Out-of-Network: 80% Outpatient/Inpatient	No Coverage
NOT PRECERTIFIED THROUGH THE MENTAL HEALTH CHEMICAL DEPENDENCY PROGRAM (MENTAL, EMOTIONAL, BEHAVIORAL, CHEMICAL ABUSE/DEPENDENCY CONDITIONS)	No Coverage	80% of Allowable Amount	No Coverage

[1]**Residential Treatment Center:** Facility must be contracted with the Claims Administrator for the level of care recommended by Provider or requested by a facility in order to be considered a covered benefit. Levels of care that are not contracted by the Claims Administrator will not be covered.

AUTISM: The BenefitsPlus Health Savings Plan medical option is the only option that provides coverage for eligible benefits on the autism spectrum, including applied behavioral analysis (ABA) therapy. Autism is a group of five related diagnoses that span a spectrum of severity. Collectively known as Autism Spectrum Disorders (ASD) or Pervasive Developmental Disorders (PDD), these diagnoses are defined by the presence of unusual behaviors and interests along with significant impairments in social interaction and communication. The five diagnoses are Autistic Disorder, Pervasive Developmental Disorder, Asperger's Disorder, Rett's Disorder, and Childhood Disintegrative Disorder. Autism Spectrum Disorders do not include mental retardation and other developmental disorders. An ASD diagnosis is typically made by a developmental pediatrician, but could also be given by a psychiatrist or psychologist. Treatment associated with autism may be covered, including speech therapy, occupational therapy, and physical therapy subject to any plan coverage limitations. Benefits may be denied or shortened for persons not progressing in goal-directed rehabilitation services or if rehabilitation goals were previously met. Benefits under this section are not available for maintenance/preventive manipulative treatment. All services under this benefit for both In-Network and Out-of-Network Providers require preauthorization or coverage will be denied. For additional information about ABA Therapy including speech therapy, physical therapy, and/or occupational therapy, you may contact the Claims Administrator 877-246-0857.

• All services for ABA Therapy and mental health services for autism for both In-Network and Out-Of-Network providers requires preauthorization, you must notify Clear Skies at (800) 742-8911 before your child receives any treatment. Coverage will be denied if you do not meet all preauthorization requirements.

EMPLOYEE ASSISTANCE PROGRAM (EAP) FOR MENTAL HEALTH: The ClearSkies Employee Assistance Program is a confidential program available to all Southwest Employees and Family Members from the day you join the Company regardless of whether you enroll in any other benefits. You do not have to be covered through one of the medical programs to be eligible. Southwest offers you the ClearSkies program so that you have a confidential resource to help you and your family deal with any personal problem that may affect your health, family life, or work including relationships, alcohol, drugs, stress, depression, and emotional distress. When you contact ClearSkies at (800) 742-8911, a licensed counselor will assess your situation, determine what assistance is needed, and provide you possible resources for treatment. You may also access ClearSkies via the web at **www.liveandworkwell.com** and use pin number: swa737

•ClearSkies is confidential and no one at Southwest will know if You call ClearSkies. Information about Your call or treatment will only be released if You consent in writing, if it is required by law, or if it is necessary to protect You or someone else.

• ClearSkies is administered by the Claims Administrator using its network of counselors and facilities to provide Covered Individuals with outpatient and inpatient mental, emotional, behavioral, and Chemical Abuse/Dependency counseling/therapy, if needed.

▪ **Steps to use ClearSkies**

1. **Identify a "warning signal"** that indicates that You or a Covered Individual may need assistance. All of the following experiences, feelings, or symptoms are "warning signals."
   - Use alcohol or drugs beyond moderation
   - Frequently feel exhausted
   - Complain about problems at home or work
   - Miss a lot of work or frequently arrive late
   - Find it difficult to concentrate at work
   - Blame other people for Your problems
   - Cry often or experience mood swings
   - Argue at the drop of a hat
   - Get depressed easily and stay depressed
   - Have trouble making decisions
   - Feel self-destructive

2. **Call the Claims Administrator at (800) 742-8911** when You first believe You need care. The Claims Administrator representatives are available 24 hours a day, seven days a week. If needed, You may receive immediate counseling during the call, otherwise, the Claims Administrator will either give You the phone number of an In-Network Provider in Your area or help make the appointment for You.

3. Your ClearSkies visit will be with a counselor that is an In-Network Provider. The counselor will ask about Your work, Your family, and Your reasons for using ClearSkies. You and Your counselor will develop a plan for Your situation. If short term counseling is appropriate, You may have up to a total of five appointments with the In-Network Provider at no charge to You.

4. If You and Your counselor decide that Your situation cannot be resolved in five sessions and an outside referral is necessary, the Claims Administrator will try to refer You to (i) resources that are covered under Your Medical Program, (ii) free resources in the community, or (iii) resources that base their fee on Your ability to pay. Your counselor will strive to recommend the most appropriate service at the least cost to You.

ClearSkies does not offer legal or financial advice, however, they may refer You to no-cost or low-cost community resources for legal problems (e.g., divorce, child custody and support, driving while intoxicated, tenant's rights) or financial problems (e.g., debt, credit, foreclosure, repossession). You will be responsible for the cost.

MENTAL, EMOTIONAL, BEHAVIORAL, AND CHEMICAL ABUSE/DEPENDENCY BENEFITS: **The Medical Program will only pay Benefits for Covered Charges for the treatment of mental, emotional, behavioral and Chemical Abuse/Dependency conditions that are Medically Necessary.**

▪There are no visit limits, however, all treatments will still be subject to the annual Out-of-Pocket Maximums, Deductibles, and Copayments that apply to the Medical Program option that You selected.

▪ If use of an Out-of-Network Provider is allowed under Your Medical Program option, then all coverage for Out-of-Network Providers is subject to the Allowable Amount.

▪ **Preauthorization requirements apply for all treatment (inpatient and outpatient) of mental, emotional, behavioral and Chemical Abuse/Dependency conditions under the Medical Program.** Certain services and/or Providers may not be covered if notification is not obtained before covered treatment/services begin. A $500 penalty fee will be applied for inpatient and certain outpatient treatments if you fail to meet all prenotification requirements. To prenotify for treatment you must follow the following steps.

1. Call the Claims Administrator to make an appointment with a local ClearSkies In-Network Provider.
2. The In-Network Provider will conduct a full assessment and contact a Care Manager.
   - If short term counseling is appropriate, then You will remain in ClearSkies with the In-Network Provider for up to five counseling sessions at no cost to You.
   - If longer term care is appropriate, then the Clear Skies In-Network Provider will present various treatment options to the Care Manager and may refer You to another In-Network Provider.
3. The ClearSkies In-Network Provider and the Care Manager will discuss Your case with Your In-Network Provider after You sign a Release of Confidentiality Form.
4. If You choose not to go through ClearSkies and/or You choose to receive treatment from a Provider who is not an In-Network Provider, Your Provider must call the Claims Administrator at (800) 742-8911 to preauthorize Your treatment. The Care Manager will discuss the case with Your Provider after You sign a Release of Confidentiality Form. **It is Your responsibility to make sure Your Provider obtains preauthorization and maintains the preauthorization with the Claims Administrator for certain services.** Your Provider must maintain the preauthorization, and You must follow the treatment plan preauthorized by the Care Manager.
5. In all cases, the Care Manager will monitor outpatient and inpatient care and will be in contact with both You and the Provider to insure continued care. If an extension of treatment is required, Your Provider must call the Claims Administrator to prenotify the extension of treatment. If the Claims Administrator does not preauthorize the extension of treatment, the treatment is not covered.

• If You fail to preauthorize treatment or if You become eligible for Benefits under the Medical Program while You are currently in on-going treatment, either outpatient or inpatient, You may be eligible for the preauthorized benefits coverage for future treatment. To qualify, You or Your Doctor must contact the Claims Administrator and the Claims Administrator will review Your treatment plan with Your Provider after You sign a Release of Confidentiality Form. **It is Your responsibility to make sure Your Provider cooperates with all of the preauthorization processes.** If the Claims Administrator preauthorizes Your future treatment plan, You follow the preauthorization treatment plan, and Your Provider maintains the preauthorization, then You will be eligible to receive benefits for charges incurred after the date the Claims Administrator preauthorized Your future treatment plan. If the Claims Administrator does not preauthorize Your future treatment plan, then the Care Manager will suggest an alternate treatment plan. If You follow the alternate treatment plan, as preauthorized by the Claims Administrator, and Your Provider maintains preauthorization, then You will be eligible to receive benefits coverage for charges incurred after the date the Claims Administrator preauthorized the alternate treatment plan.

• In addition to the steps listed above, to preauthorize for hospital stays or residential treatment centers you must also complete the following additional steps.

1. The Claims Administrator will ask why the hospitalization is needed, what treatments are needed and how long the stay will be.
2. The Claims Administrator decides if the Hospital stay is Medically Necessary.
3. If the Hospital stay is not Medically Necessary, Your Medical Program will not pay Benefits for the Hospital stay.
4. If the Hospital stay is Medically Necessary, the Claims Administrator will tell You how many days of hospitalization are allowed and establish a timeframe for continued stay review.
5. If You stay in the Hospital longer than the appointed time, Your Medical Program will not pay Benefits for those days unless the Claims Administrator establishes the Medical Necessity of the extended stay.

• **If a Covered Individual is admitted to the Hospital on an emergency basis, You or the Doctor must call the Claims Administrator within two working days of the admission for preauthorization.** If You or the Doctor do not call the Claims Administrator for preauthorization before Your hospitalization or within two working days of an emergency admission, the treatment is not covered. If the Claims Administrator denies preauthorization of Your Hospital stay, Your hospital stay will not be covered. If You obtain preauthorization for a Hospital stay but Your length of stay exceeds the timeframe preauthorized by the Claims Administrator, the portion of the stay that was not preauthorized will not be covered.

• **If You are admitted to a Residential Treatment Center without preauthorization, it will not be covered.** The Medical Program excludes charges for residential treatment unless approved by the Claims Administrator prior to admission for covered residential treatment facilities. Residential Treatment is subject to the Claims Administrator's residential treatment criteria for covered treatment and criteria for covered residential treatment facilities.

SKILLED NURSING FACILITY: A Skilled Nursing Facility provides Room and Board in a Semi-private Room and routine nursing care for patients who need a place for recovery but do not need the level of care provided in a Hospital. Admission to a Skilled nursing Facility must be prescribed by a Physician. In general, the intent of skilled nursing is to provide benefits for Covered Individuals who are convalescing from an illness or other injury that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

Notification Requirements apply to all Skilled nursing Facility services. Benefits are available only if (i) the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and you will receive skilled care services that are not primarily Custodial Services. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when (i) it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; (ii) it is ordered by a Physician; (iii) it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and it requires clinical training in order to be delivered safely and effectively.

• If the Skilled Nursing Facility is an all private room facility, then the Plan will pay Room and Board charges up to the Allowable Amount semi-private rate of area skilled nursing facilities.

• The Covered Individual is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeding) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Individual or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.

HOSPICE CARE: When a Covered Individual is terminally ill, hospice care may be an alternative to staying in the Hospital. Hospice care that is recommended by a Physician is intended to be an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members.

- Notification requirements apply to all Hospice Care services.

- The Plan pays covered hospice care charges if a Physician certifies that the Covered Individual (i) is terminally ill and (ii) has a life expectancy of six Months or less. Any Covered Charge paid under the Hospice Care Benefits will not be considered a Covered Charge under any other Benefits in the Plan.

- Benefits are only available when hospice care is received from a licensed hospice agency. The Plan pays for the following hospice care charges only (i) Semi-private Room and Board for confinement, (ii) services and supplies provided by the hospice while confined, (iii) parttime nursing care by or under the supervision of a registered nurse,(iv) Home Health Aide services, (v) nutritional services, (vi) special meals, and (vii) counseling services provided by a licensed social worker or a licensed pastoral counselor.

- In addition to covered hospice care charges, the Plan pays covered charges for bereavement counseling by a licensed social worker or pastoral counselor for Covered Individuals under the Plan. This may not exceed longer than six Months after the patient's death.

HOME HEALTH CARE: Some skilled health care provided in the Covered Individual's home may qualify for Home Health Care coverage if all of the following requirements are met. A service will not be determined to be "skilled" simply because there is not an available caregiver.

- **You must meet advance notification requirements before receiving Home Health Care Services.** The Claims Administrator will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician directed medical management.

- Benefits are available only when Skilled Home Health Care Services are provided by a Home Health Care Agency on a part-time, intermittent scheduled basis and when skilled Home Health Care is required.

- Skilled Home Health Care Services include skilled nursing, skilled teaching, and skilled rehabilitation services that meet all of the following requirements:

(i) must be ordered and directed by a Physician and delivered or supervised by a Physician or Registered Nurse in the Covered Individual's home;
(ii) may not be delivered for the purpose of assisting with activities of daily living, including but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair;
(iii) clinical training to be delivered safely and effectively;
(iv) not Custodial Services or general housekeeping services; and
(iv) for BENEFITSPLUS—CHOICE PLAN C and REGULAR PLAN MEDICAL OPTION options also require that (i) the treatment plan is certified by a Physician and (ii) the Covered Individual is examined by a Physician at least once every sixty days.

- If any services or supplies rendered in conjunction with the home health care are covered Charges elsewhere in the Medical Program, then the expense will not be considered a home health care expense.

CONGENITAL HEART DISEASE (CHD) SERVICES: Congenital Heart Disease services may be covered but only if the services meet the definition of a Covered Health Service and are not Experimental, Investigational, or Unproven.

- **Notification Requirements apply to all CHD services,** including outpatient diagnostic testing, in utero services and evaluation, congenital heart disease surgical interventions, interventional cardiac catheterizations, fetal echocardiograms, and other fetal interventions. CHD services other than those listed are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

- **CONGENITAL HEART DISEASE RESOURCE SERVICES:** CHD services, when ordered by a Physician, may be received at a facility designated by the Claims Administrator as part of a Congenital Heart Disease Resource Services program. If You use a Congenital Heart Disease Resource Services program that is more than 50 miles from the Covered Individual's residence, then the Covered Individual and a companion may be eligible for transportation and lodging benefits described below not to exceed an overall lifetime maximum Benefit of $10,000 per Covered Individual.

- Transportation of the patient and one companion (two companions if the Covered Individual is a child) who is traveling on the same day(s) to and/or from the site of CHD services for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow-up.

- Eligible Charges for lodging for the patient (while not confined) and companion(s) paid at a per diem rate of up to $50 for one person or up to $100 for two or more people, as applicable.

TRANSPLANTATION SERVICES: The Medical Program will pay for organ and tissue transplant when ordered by a Physician if the transplant meets the definition of a Covered Charge and is not an Experimental, Investigational, or Unproven transplantation service. **Notification requirements apply for all transplant services.** There are specific guidelines under all Medical Program options for transplant services.

- The donor costs directly related to organ removal for an organ transplant in which a Covered Individual is the organ recipient are Covered Health Services for which Benefits are payable through the Covered Individual's coverage under the Plan. Donor costs related to organ removal from a Covered Individual for transplant to another individual are not covered under the Plan.

- Examples of transplants for which Benefits are available include, but are not limited to, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/kidney, liver/intestinal, pancreas, intestinal, and bone marrow (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. Benefits may also be available for cornea transplants that are provided by a Physician at a Hospital.

- Travel, lodging, and transportation of the patient and one companion (two companions if the Covered Individual is a child) who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, and/or necessary post-discharge follow-up. Eligible Charges for lodging for the patient (while not confined) and companion(s) paid at a per diem rate for one person or two people, as applicable. Eligible Charges for lodging for the patient (while not confined) and companion(s) paid at a per diem rate of up to $50 for one person or up to $100 for two or more people, as applicable. Covered Individual and a companion may be eligible for transportation and lodging benefits described below not to exceed an overall lifetime maximum Benefit of $10,000 per Covered Individual.

- Not Covered: Health services for organ transplants, except those described above; health services for transplants involving mechanical or animal organs; any solid organ transplant that is performed as a treatment for cancer; any multiple organ transplants not listed as a covered benefit above. In addition, if the donor is not covered under the plan, then donor expenses are not covered.

REGULAR PLAN MEDICAL OPTION—ACCIDENT BENEFIT: Under the Regular Plan medical option, if a Covered Individual incurs charges as a result of an accidental bodily injury which is not a preexisting condition, the first $300 of Covered Charges related to that accident and incurred by each Covered Individual within three Months after the date of the injury will be paid at 100%. All Covered Charges incurred above the first $300 associated with that specific accident will be subject to the Deductible and Out-of-Pocket maximum and will be paid in accordance with the other provisions of the Regular Plan medical option. This accident benefit will be paid for the following services, supplies, and treatment: (i) medical, dental, or surgical treatments or supplies; (ii) Hospital or Skilled Nursing Facility charges; (iii); x-ray or lab charges; (iv) prescription drugs; (v) medical care or surgical treatment by a Physician; (vi) services by a registered nurse for private duty nursing; and (vii) services by a licensed practical nurse for private duty nursing while confined in a Hospital.

BENEFITSPLUS—ADDITIONAL BENEFIT FOR CATASTROPHIC ILLNESS OR ACCIDENT PRIOR TO 2001: If, during a Calendar Year ending on or before December 31, 2001, a Covered Individual individually incurred Covered Charges in excess of the qualifying amount for one illness or accident in the Calendar Year (excluding any Covered Charges relating to dental conditions, prescription drugs, or infertility treatment), then the Medical Program pays 100% for future Covered Charges relating to that illness or accident for the remainder of that Calendar Year and succeeding Years for which the Covered Individual has coverage under the same Medical Program option. The Annual Deductible will not apply to Covered Charges for that illness or accident in succeeding Years during which you have the same Medical Program option. If You have a qualifying pre-2002 catastrophic illness or accident, then if You change from Your Medical Program option to another option, You will no longer be eligible for this benefit.

REGULAR PLAN—ADDITIONAL BENEFIT FOR CATASTROPHIC ILLNESS OR ACCIDENT: If, during any Calendar Year, You or a Covered Family Member individually incurs Covered Charges in excess of $12,500 for one illness or accident in that Calendar Year (excluding any Covered Charges relating to prescription drugs), then the Plan will pay 100% of future Covered Charges relating to that illness or accident for the remainder of that Calendar Year and each succeeding year for which you select coverage under the Regular Plan. The Calendar Year Deductible will not apply to Covered Expenses for that illness or accident in succeeding years provided You continue coverage in the Regular Plan.

TREATMENT DECISION SUPPORT FOR BENEFITSPLUS: To help You make informed decisions about Your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets treatments and procedures for specific conditions. Participation is completely voluntary and without extra charge. If You think You may be eligible to participate or would like additional information regarding the program, please contact the number on the back of Your ID card. This program offers (i) access to accurate objective and relevant health care information, (ii) coaching by a nurse through decisions in Your treatment and care, (iii) expectations of treatment, and (iv) information on high quality Providers and programs. Conditions for which this program is available include (i) back pain, (ii) knee and hip replacement, (iii) prostate cancer, (iv) benign uterine conditions, (v) breast cancer, (vi) coronary disease, and (vii) bariatric surgery.

BENEFITSPLUS HSP—HEALTH SAVINGS ACCOUNT (HSA): A Health Savings Account (HSA) is only available under the BenefitsPlus Health Savings Plan (HSP) option. If you enroll in the BenefitsPlus HSP medical option, you will have the option, if you meet IRS requirements, to open a Health Savings Account (HSA) to save money for qualified medical expenses. You may choose to open a HSA with any bank. If you open your account with Optum Bank, then the amount that you choose to save can be withheld from your paycheck before taxes and direct deposited to your HSA. If you open a HSA with another bank, you may make contributions directly (for example, by personal check) but payroll deductions will not be available to you. The amount in your HSA is yours to use for qualified medical expenses, including your Deductible under the HSP. You do not lose amounts in your HSA at the end of the Year or when your employment with Southwest ends. It's your money! You may also choose for amounts in your HSA to earn interest and grow tax-free for use on qualified medical expenses in the future.

- **To participate in the HSA, you will need to personally open your own account.** You can either (i) choose to have Southwest deduct your HSA contributions directly from your paycheck, in which case you must open your own account with Optum Bank (see details below), or (ii) choose to make direct contributions (for example, by personal check) to your HSA in which case you may open a HSA with the bank of your choice. To open a **HSA with Optum Bank**, you must go to www.OptumBank.com to complete the bank's online application including Southwest Airlines' Group Number 199409. Your elected pre-tax payroll contributions will not begin until you open your account with Optum Bank. Once your account is open, a debit Mastercard will be mailed to your home address. You must open a HSA and have funds in your HSA before you can use your account to pay for qualified medical expenses. You may only use your HSA to pay for medical expenses incurred after the account is opened. **Pre-tax payroll contributions** can only be made to a Health Savings Account with Optum Bank. If you open your Health Savings Account with another bank, contributions cannot be pre-tax payroll deducted, although they may be considered a tax deduction when filing your annual tax return. Consult your tax advisor for details.

- For 2013, You may contribute up to $3,250 for Employee Only coverage and $6,450 for all other coverage levels. If you will be at least 55 Years old during the Year, you may contribute an additional $1,000. If you choose to make payroll deductions, you may change your HSA contribution amount at any time during the Year by logging on to SWALife>About Me>My Benefits>HSA Election.

- Most Southwest Employees who are enrolled in the BenefitsPlus HSP medical option will be eligible to open a HSA; however, federal tax law limits participation in a HSA in some circumstances. Make sure you understand these limitations before you make your elections. These eligibility requirements only apply to the HSA, not the HSP medical option. If you enroll in the HSP intending to open a HSA, but then determine you are not eligible for the HSA, you will not be able to change to another medical option until the next annual enrollment period for the Plan. To be eligible to open a HSA:

  - You may ONLY have medical coverage under the BenefitsPlus HSP medical option.
  - You may not be enrolled in Medicare (Part A or B), TRICARE or TRICARE for Life, even as secondary coverage. (If you are eligible for Medicare, but not enrolled, then you are eligible to contribute to a HSA.)
  - You must not have received Veteran Administration (VA) Medical Benefits within three Months of making any contribution to your HSA.
  - You may not be claimed as a dependent on someone else's tax return.
  - You, and your spouse (if any), may not contribute to a Health Care FSA; however, you may contribute to a Dependent Care FSA.

- Although a Committed Partner may be covered under the HSP, under federal tax rules, the Committed Partner's medical expenses usually will not constitute qualified medical expenses that may be paid or reimbursed out of a HSA.

CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES: To be covered, Benefits must be medically appropriate and consistent with UnitedHealthcare medical policy, and given for the diagnosis or treatment of a Sickness or accidental Injury that is imminently probable. A covered individual and his or her Physician must decide which service and supplies are given, but the Plan only pays Eligible Charges for Covered Health Services as determined by the Claims Administrator. This chart provides a general listing of covered and non-covered expenses. To determine if a procedure or service is covered it is advised that Your Physician submit a predetermination of benefits to the administrator that is processing Your specific claims.

For Copayment, Coinsurance, Deductibles, Out-of-Pocket Maximums and In-Network/Out-of-Network benefit coverage amounts, refer to the Medical Program Options Comparison Chart above.

In addition to the Not Covered items listed below, benefit exclusions include but are not limited to: services or supplies that are not a covered health service; charges which are not considered a covered health service or which are not medically necessary or which are not necessary to the care and treatment of an illness; drugs, treatment, or supplies considered investigational, unproven or experimental; and expenses for confinement treatment or supplies

The charge below is not an all-inclusive listing of expenses covered and not covered. Basically, Benefits are payable under the Medical Program only for those services which are considered Covered Health Services and which are Medically Necessary for the treatment of non-occupational accidents or illnesses.

	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN
Abortion	Elective and Therapeutic—An abortion to terminate a pregnancy shall be covered only for You (if You are female) or Your Spouse or Committed Partner (if You are male).	Covered	Covered Dependent Daughter: Not Covered
Acupuncture	Acupuncture services for pain therapy provided that the service is performed in an office setting by a Provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: Doctor of Medicine; Doctor of Osteopathy; Chiropractor; or Acupuncturist. Covered Health Services include treatment of nausea as a result of: chemotherapy; pregnancy; and post-operative procedures. Any combination of In-Network Benefits and Out-of-Network Benefits is limited to $1,000 per Calendar Year.	Covered: Choice Plus Plan HSA Not Covered: Choice Plan C	Not Covered
Alternative Treatments	The following Alternative Treatments are not covered: acupressure; alternative treatments ; Aromatherapy; hypnotism; massage therapy; rolfing; or other forms of alternative treatments as defined in the Office of Alternative Medicine of the National Institutes of Health	Not Covered	Not Covered
Ambulance: Ground & Air	**Ground Ambulance:** Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where emergency health services can be performed. Medically Appropriate ambulance charges will be covered only if the illness cannot be adequately treated in the location where the illness or accident occurs. Nonemergency ambulance services require preauthorization. **Air Ambulance:** Preauthorization is required. Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put the patient's life or health in serious jeopardy. If special circumstances exist, the administrator may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency health services. In a non-emergency situation, when ground transportation is inappropriate for the medical condition of the person requiring transportation, the administrator may pay Benefits for facility to facility air transportation.	Covered	Covered
Ambulatory Surgical Center	Any licensed distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.	Covered	Covered
Allergy Care	Testing in Physician's office, treatment (injection administered by a nurse). Skin testing covered, excluded skin end point titration and any other testing considered experimental, investigational or unproven	Covered	Covered
Anesthesia	Anesthetics and their administration, including if administered by a licensed Certified Registered Nurse Anesthetist (CRNA). If a CRNA and a licensed anesthesiologist or anesthetist charge for the same anesthetic service (type and date of service) the anesthesiologist or anesthetist charges will be paid and the CRNA charges will be denied Dental Anesthesia: 1. The patient is under the age of 7, or 2. The patient is developmentally disabled, or 3. The patient's safety is at risk. Coverage for anesthesia and associated facility Charges is subject to all of the same terms and conditions as for other Covered Health Services. Personal Health Support should be notified. All other Charges for the dental procedure(s) itself, including but not limited to the professional fees of the Dentist are not covered.	Covered	Covered
Assistant Surgeon		Covered	Covered
Audiologist	Coverage includes: Charges by a licensed or certified audiologist for Physician prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm organic hearing problem.	Covered	Covered
Bereavement Counseling	Counseling benefits covered for the immediate family if the patient was receiving hospice care covered under the medical plan. Counseling must be received within six Months after the patient is deceased. 16 visits / sessions per family member within six Months after patient is deceased. Provider may also be pastoral counselor or a licensed counselor.	Covered	Covered
Birthing Center	Pre-authorization is required for days beyond the mandated length of stay.	Covered	Covered
Blood Plasma	Preservation of autologous blood products for scheduled surgery for up to eight weeks.	Covered	Covered
Breast Reconstruction/Reduction	Breast Reconstruction Surgery if required as a result of a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Reconstructive procedures—services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. **Excluded:** Cosmetic procedures including reduction mammoplasty for non-medical reasons or services that change or improve appearance without significantly improving physiological function.	Covered	Covered
Cardiac Rehabilitation Services	Services must be performed by a licensed therapy Provider under the direction of a Physician. Benefits are available only for the rehabilitation services that are expected to result in significant improvement in the patient's condition.	Covered	Covered
Chemotherapy		Covered	Covered
Chiropractic Care/Spinal Manipulation	ChoicePlus Plan and HSP: 30 visits per Calendar Year and combined with In-Network and Out-of-Network; one visit per day. Additional visits may be authorized following clinical review. Choice Plan C and Regular Plan: No visit limits.	Covered	Covered

	Chart of Covered/Not Covered Conditions and Services (See additional exclusions at end of chart.)	BenefitsPlus	Regular Plan
Christian Science Practitioners		Not Covered	Not Covered
Cochlear Implant	Diagnosis of severe to profound bilateral sensor neural hearing loss and severely difficult speech discrimination. Post-lingual sensor neural deafness in an adult.	Covered	Covered
Cranial Banding	For infants with abnormal headshape.	Covered	Covered
Dental Care for Accident/Injury Only	Pre-authorization required Will include facility and anesthesia charges for dental care but not the actual dentist charges when required The repair or replacement of natural teeth as a result of an accidental bodily injury or the treatment of a malignant condition of the gums or supporting tissue of the teeth, and the treatment to restore any lost function as a result of the malignant condition. Dental care not described above is excluded. The Medical Program does not cover except as described under the eligibility section: preventive care, diagnosis and treatment of or related to teeth, jawbones or gums; extraction, restoration, replacement, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes; dental implants; dental braces; dental x-rays, supplies, and appliances including hospitalization and anesthesia (except for transplant preparation) initiation of immunosuppressive, direct treatment of an acute traumatic injury; cancer; treatment of congenitally missing, malposition or supernumerary teeth, even part of congenital anomaly; gingivectomy; alveolectomy; or extraction of impacted teeth, including wisdom teeth.	Covered	Covered
Dental Care (Dental Anesthesia)	Limitation: Dental Anesthesia (facility and anesthesia charges) for children when required due to patient age or patient safety. Charges from the dentist for all dental procedures must be filed with the dental plan.	Covered	Covered
Diabetic Supplies	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy service. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. Diabetic Self-Management Items: Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including: blood glucose monitors; insulin syringes with needles; blood glucose and urine test strips; ketone test strips and tablets; and lancets and lancet devices	Covered	Covered
Dialysis		Covered	Covered
Drugs	Prescription drug products for outpatient use that are filled by prescription order or refill. Non-injectable medications given in a Physician's office except as required in an Emergency (i.e. samples given by the Provider) Over-the-counter drugs and treatments Experimental, investigational or unproven drugs Vitamins, food supplements, minerals and other dietary supplies	Not Covered	Not Covered
Durable Medical Equipment	• Pre-authorization is required on any expense over $1,000. • Must meet all of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes • Not consumable or disposable Not of use to a person in the absence of a disease or disability • If more than one piece of durable medical equipment can meet the patient's functional needs, durable medical equipment benefits are available only for the most Cost Effective piece of equipment. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (excluded are: air conditioners, humidifiers, de-humidifiers, air purifiers and filters). • Durable medical equipment can be replaced after 3 Years or; at medical plan discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three Year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary durable medical equipment are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three Year timeline for replacement. • Duplicate prosthetics, appliances cost for the replacement of stolen prosthetic devices, and prosthetics that are less than five Years old (except as listed below) are not covered. • Covers devices that replace a limb or body part including: Artificial limbs, Artificial Eyes, Breast Prosthesis (as required by the Woman's Health and Cancer Right's Act of 1998). • If more than one prosthetic device can meet the participant's functional need, benefits are available for the most Cost Effective prosthetic device. • Prosthetics: see Prosthetic Devices. Covered Orthotics: • Braces or orthotics that stabilize an injured body part and braces to treat curvature of the spine. • Shoe/foot orthotics – Physician prescribed, custom made orthotics to treat an injury or illness. • Diabetic footwear for a person with diabetic foot disease.	Covered	Covered